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

☐ **Interim** ☒ **Final**

Date of Report 5/7/19

Auditor Information

Name: Noelda Martinez	**Email:** martinezauditingservices@yahoo.com
Company Name: Martinez Auditing Services, LLC	
Mailing Address: P. O. Box 372	**City, State, Zip:** Beeville, TX 78102
Telephone: (210) 790-7402	**Date of Facility Visit:** April 1-2, 2019

Agency Information

Name of Agency: CoreCivic		**Governing Authority or Parent Agency** *(If Applicable)*: N/A	
Physical Address: 10 Burton Hills Blvd.		**City, State, Zip:** Nashville, Tennessee 37215	
Mailing Address: -		**City, State, Zip:** -	
Telephone: (615) 263-3000		**Is Agency accredited by any organization?** ☐ Yes ☒ No	
The Agency Is:	☐ Military	☒ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

Agency mission: We deliver proven and innovative practices in settings that help people obtain employment, successfully reintegrate into society and keep communities safe.

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

Agency Chief Executive Officer

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

Agency-Wide PREA Coordinator

Name: Eric S. Pierson	**Title:** Sr. Director, PREA Compliance and Programs

Email: eric.pierson@corecivic.com	**Telephone:** 615-263-6915
PREA Coordinator Reports to: Steve Conry, Vice President, Operations Administration	**Number of Compliance Managers who report to the PREA Coordinator** 63

Facility Information

Name of Facility: Corpus Christi Transitional Center			
Physical Address: 1515 N. Tancahua Street, Corpus Christi, TX 78401			
Mailing Address (if different than above): -			
Telephone Number: 361-225-9384			
The Facility Is:	☐ Military	☒ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

Facility Type:	☒ Community treatment center	☐ Halfway house	☐ Restitution center
	☐ Mental health facility	☐ Alcohol or drug rehabilitation center	
	☐ Other community correctional facility		

Facility Mission: We deliver proven and innovative practices in settings that help people obtain employment, successfully reintegrate into society and keep communities safe.

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

Have there been any internal or external audits of and/or accreditations by any other organization? ☐ Yes ☒ No

Director

Name: Christina Russell	**Title:** Facility Administrator
Email: christina.russell@corecivic.com	**Telephone:** 361-225-9384

Facility PREA Compliance Manager

Name: Christina Russell	**Title:** Facility Administrator
Email: christina.russell@corecivic.com	**Telephone:** 361-225-9384

Facility Health Service Administrator

Name: none	**Title:** -
Email: -	**Telephone:** -

Facility Characteristic			
Designated Facility Capacity: 158		**Current Population of Facility:** 130	
Number of residents admitted to facility during the past 12 months			796
Number of residents admitted to facility during the past 12 months who were transferred from a different community confinement facility:			663
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 30 days or more:			663
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:			796
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:			0
Age Range of Population:	☒ Adults 18-75	☐ Juveniles none	☐ Youthful residents none
Average length of stay or time under supervision:			30-90 days
Facility Security Level:			Treatment Center-Intensive and Residential
Resident Custody Levels:			Treatment Center-Intensive and Residential
Number of staff currently employed by the facility who may have contact with residents:			40
Number of staff hired by the facility during the past 12 months who may have contact with residents:			25
Number of contracts in the past 12 months for services with contractors who may have contact with residents:			0

Physical Plant	
Number of Buildings: 6	**Number of Single Cell Housing Units:** 0
Number of Multiple Occupancy Cell Housing Units:	6
Number of Open Bay/Dorm Housing Units:	0

Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.):

The facility had a total of 29 cameras and are only viewed by the designated monitoring staff with a retention of 30 days. The cameras are serviced by Alarm Security Services.

Medical	
Type of Medical Facility:	N/A
Forensic sexual assault medical exams are conducted at:	Nearby Hospital

Other	
Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:	0C/10V
Number of investigators the agency currently employs to investigate allegations of sexual abuse:	2

Audit Findings

Audit Narrative

The auditor's description of the audit methodology should include a detailed description of the following processes during the pre-onsite audit, onsite audit, and post-audit phases: documents and files reviewed, discussions and types of interviews conducted, number of days spent on-site, observations made during the site-review, and a detailed description of any follow-up work conducted during the post-audit phase. The narrative should describe the techniques the auditor used to sample documentation and select interviewees, and the auditor's process for the site review.

The Prison Rape Elimination Act (PREA) certification audit for the Corpus Christi Transitional Center (CCTC), CoreCivic in Corpus Christi, Texas was conducted on April 1-2, 2019, to determine the compliance of the Prison Rape Elimination Act Standards. The audit was conducted by Noelda Martinez (single auditor), United States Department of Justice Prison Rape Elimination Act Certified Auditor. The agency contract was secured through Martinez Auditing Services, LLC directly by the auditor. The contract describes the specific work required according to the Department of Justice (DOJ) standards and PREA audit handbook to include the pre-audit, onsite audit and post-audit. The contract was signed by the auditor on 12/10/18 and clearly describes the lead auditors' responsibilities. The first PREA audit for CCTC was conducted by PREA auditor Barbara Jo Denison on April 4-5, 2016. The previous auditor determined the CCTC exceeded three standards, met 33 standards and the other three were non-applicable.

Audit Methodology (Pre-Onsite Audit Phase):
The auditor utilized the paper audit instruments for community confinement facilities which included the pre-audit questionnaire, auditor compliance tool, instructions for PREA audit Site Review, interview protocols: Agency Head or Designee, Facility Director or Designee, PREA Coordinator, Specialized staff, Random Staff and Residents. The auditor also used the PREA auditor handbook for continued guidance, audit report template, process map and checklist of documents. The auditor established a positive working relationship with the Facility Director and key facility staff engaging in a productive working atmosphere. It was explained to the Facility Director about the importance to have unfettered access to all areas of the facility, file review of personnel contractors, volunteers, and residents to include a variety of sensitive and confidential documentation and information referencing standard 115.401 (*PREA Auditor Handbook pg. 32 & 37*). The facility provided the auditor with a resident roster for random selection of residents, staff roster for selection for specialized staff and random interviews. The Facility Director understood the importance of the audit process and review and with no hesitation provided access to the auditor. The auditor explained the 30-day interim report if corrective action was required and the 180-day corrective action timeframe, if needed. The auditor explained to the facility director the 45-day time frame for the submission of the final PREA report. The auditor also notified the facility director and staff of her responsibilities and expectations as an auditor and the agencies right to report any violation of the auditors code of conduct to the PREA Resource Center. The facility director and auditor discussed information regarding the 90-day appeal process.

Communication:
CoreCivic Senior Director for the PREA Programs and Compliance forwarded the facility documents and information to the auditor through a secured website on 3/2/19. The secured website provided the following information: PREA Audit files with samples, PREA policies, the audit notice in both English and Spanish with the audit dates and mailing address for the resident population; list of residents who reported sexual abuse; resident roster and housing locations, Employee list, (contracts reviewed onsite), annual reports; staffing plans; mission statement; daily population; facility schematic; lesson plan for volunteers, correctional programs division,

language line, PREA overview participant workbook, PREA overview facilitator guide, organizational chart; pre-audit questionnaire, and assigned Senior Director for PREA programs. The Senior Director for PREA emailed on 3/3/19 for Point of Contact (POC) information and communication. On 3/3/19, the Senior Director for PREA provided the POC information for CCTC. The auditor sent an email to the facility as an introduction to include the Pre-Audit Questionnaire, Site Review Instructions, Interview protocols, Process map, & Checklist of documentation. Most of the requested information was provided to the auditor on 3/2/19 prior to this email through a secured website by the Senior Director for PREA. The following information was provided to the auditor.

1. A list of all allegations of sexual abuse and sexual harassment received in the previous 12 months at the facility including the outcomes of investigations, whether they were administrative or criminal and whether any allegations were forwarded to the district attorney for consideration of prosecution.
2. Diagram of the physical plant
3. List of residents, alphabetical and by housing unit
4. List of residents who are identified to meet one or more of the targeted resident categories:
    a. Youthful residents, if any
    b. Residents with a physical disability
    c. Residents who are Blind, Deaf or hard of hearing
    d. Residents who are Limited English Proficient
    e. Residents with a Cognitive Disability
    f. Residents who identify as Lesbian, Gay, Bisexual,
    g. Resident who identify as Transgender or Intersex
    h. Residents who Reported Sexual Abuse
    i. Residents who Reported Sexual Victimization during Risk Screening
    j. Random Resident interviews
    k. List of staff by shift, including position title
    l. All contractors who have contact with residents
    m. All volunteers who have contact with residents
    n. All grievances made in the 12 months preceding the audit
    o. All incident reports from the 12 months preceding the audit
    p. All hotline calls made during the 12 months preceding the audit
    q. Audit notice posting and dates, policies and procedures, PREA files and samples, PAQ and additional required information.

The email included the list of specialized staff required for interviews during the onsite visit.
• Agency contract administrator
• Medical and mental health staff
• Administrative (human resources) staff
• Sexual Assault Forensic Examiner (SAFE) and Sexual Assault Nurse Examiner (SANE) staff
• Volunteers and contractors who have contact with residents
• Investigative staff
• Staff who perform screening for risk of victimization and abusiveness
• 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
• Random staff

The following facility and agency leadership were interviewed: • Agency head or designee • Facility Director/facility director/superintendent or designee • PREA coordinator.

Point of Contact:
A point of contact (*POC*) was established with the facility prior to the audit and constant communication was maintained. The auditor and facility director discussed the location for interviews and decided that the interviews would be conducted in the conference room with plenty of room and privacy for the auditor to conduct staff and resident interviews. During the audit planning and logistics phase, the auditor remained engaged with the Facility Director/PREA Manager, and Senior Director regarding the audit process, expectations, and coordinated the logistics of the onsite portion of the audit. The memorandum also discussed the transportation, daily schedule, work space, adequate outlets, permissible technology (laptop, cell phone) and other necessary audit materials and information required. The auditor focused on multiple sources of information during the audit process applying audit planning & logistics, posting notice of the audit, reviewing facility policies, procedures, supporting documentation and conducting outreach to advocacy organizations.

Internet Search:

The auditor conducted a google search for articles related to the Corpus Christi Transitional Center for the past 12 months. The auditor discovered three articles with information about the facility. The Facility Director was interviewed and stated there is no information on record of any current litigation, consent decrees or local oversight under the contract.

www.corecivic.com/facilities/corpus-christi-transitional-center
www.correctionscorp.com/facilities/avalon-corpus-christi-transitional-center

https://www.transitionalhousing.org/li/tx_78401_corpus-christi-transitional-center

Outreach/Community Based Victim Services:
The auditor reviewed the Memorandum of Understanding between CoreCivic of Tennessee, LLC/Corpus Christi Transitional Center (CCTC) and the Purple Door. The document establishes guidelines for the provision of victim services to residents in custody by and between Corpus Christi Transitional Center and Women's Shelter of South Texas D/B/A/ The Purple Door. The Purple door agrees to arrange for forensic examinations for resident victims of sexual abuse, such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs), follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. Provide a victim advocate, if requested by the victim; contact facility personnel and provide the identity of the victim advocate responding to the forensic exam. Provide 24-hour sexual abuse/assault crisis line number and the Purple Door mailing addresses that may be posted throughout the facility and in written resources given to residents. On 4/1/19, the 24-hour Crisis Hotline was tested by the auditor and was in good working condition, the representative stated that no calls had been received from the facility. On 4/1/19, the auditor contacted the SANE/SAFE nurse on-call, the process for a sexual assault was explained, and no other information was disclosed regarding the facility on that specific night. The residents interviewed by the auditor understood how to contact the rape crisis center directly at any time if needed.

The auditor utilized the resident and employee roster to make the selections for interviews, file reviews and investigations. The employees were selected by category using the specialized staff protocol and random interview protocol. The resident population was selected by category using the targeted resident protocol and random interview protocol. The random resident interviews were selected by choosing the 1st, and 10th name to include race, gender and housing location to ensure an equal distribution of the diverse population was interviewed. The pre-onsite audit preparation included a review of the CoreCivic policies, procedures, training curriculums, pre-audit questionnaire and supporting PREA-related documentation provided by the agency to demonstrate compliance of the PREA Standards and certification process.

The facility posted the notice of audit with the auditor information six weeks prior to the audit in both English and Spanish for residents to send confidential information or correspondence to the auditor. Residents are allowed to write the auditor in a confidential manner marked as legal mail. The notices were posted throughout the facility to include visitation, housing units, dining area and restrooms. The auditor verified the audit notice by an email forwarded from the facility on 3/2/19 and notices were posted on 2/8/19.

First Day Introduction:
On the first day of the audit 4/1/19 an introductory meeting was held with the following staff in attendance: Senior Director for PREA programs, Facility Administrator, TDCJ monitors and additional staff. The resident population on the first day of the onsite audit was 130, housing adult male residents. The auditor was provided an area in the conference room with privacy to conduct the file reviews. The requested files for staff and residents were made available to the auditor upon request with no hesitation or delay. Following the introductory meeting, the auditor was escorted by the Facility Director, TDCJ contract monitors and additional staff for the site review. The auditor observed the operations at the facility and was given unimpeded access to areas requested by the auditor. The auditor spent two days on the unit to observe and assess the day-to-day practice of the staff's interaction and promotion of the overall sexual safety. During the Site Review, the auditor randomly talked to residents and staff in the food service area, housing units, dayroom and random Monitors I, II, and III regarding the reporting and notification process for sexual abuse allegations. The staff interviewed by the auditor were able to articulate the process in a consistent manner.

On-Site Audit Phase:
The main building of the facility houses administrative offices, dining room, kitchen, day area, hallway restrooms and dorms. The site review began on 4/1/19, the auditor observed the administrative building designated for the counselors with cubicles and offices to include the file room storing client binders. The facility had a total of eight counselors for the resident program. The administrative building had one camera with no security mirrors and requires for two staff members to be present when residents are in counseling. There have been no upgrades to the facility in the past 12 months according to the Facility Director. Strip searches of male residents are prohibited and monitors of the same gender conduct pat-searches.

The auditor entered F-dorm with a capacity of 24 residents, the female staff verbally made the announcement of a female entering the dorm. There was one camera in the dayroom and no security mirrors. The dorm is an open concept and the auditor had a clear view of the area with no blind spots in sight. The dayroom lights were on with clear visibility and the area was clean. The restroom and showers were designated on the left with no visibility of cross-gender viewing. The male residents have five individual restroom stalls with full doors and complete privacy from the opposite-gender. The male employee cleared the restroom and shower area prior to the female auditors entrance for observation in the area. The shower area had three separate individual showers with full shower curtains providing sufficient privacy from the opposite-gender. The restrooms and showers had the PREA signs displayed in a large frame in both English and Spanish for easy visibility. The shower area had one handicap shower and the restroom had one handicap stall. The dayroom had a telephone for the residents with the PREA signs displayed in both English and Spanish, six TDCJ PREA numbers and hotlines, and the Purple Door 24-hour Sexual Assault Crisis Hotline. The PREA Audit notification was posted and dated 2/8/19. The dayroom had the PREA signs displayed in a large frame in both English and Spanish. The auditor opened one closet area which secured the heater and did have limited access to keys and lighting.

E-dorm was observed during the site review with a capacity of 24 residents, the female staff verbally made the announcement of a female entering the dorm. The dorm was only occupied by five residents at the time of the site review. The showers and restroom were inoperable and closed off due to the remodeling of the area. The facility provided documentation of the contract for the remodeling portion of the area. The five residents were utilizing the shower and restroom in the main building which was observed by the auditor with sufficient amount of privacy doors and shower curtains from the opposite gender.

The auditor tested the phone in E-dorm, and it was in working condition. The Purple door and PREA information was posted for resident use. The auditor opened the closet door for the use of staff limited access and sufficient lighting. There was one camera in the dayroom and no security mirrors. The dorm is an open room with a clear view of the area with no blind spots in sight. The dayroom lights were on with clear visibility. The PREA Audit notification was posted and dated 2/8/19. The dayroom had the PREA signs displayed in a large frame in both English and Spanish.

The auditor observed the monitor station, which is open 24 hours a day, 7 days a week with an assigned employee/monitor to for resident check in/out. The monitor station has one camera in direct view of the pat-search area for clear visibility of staff and resident interaction. The Facility Director and Operations supervisor are responsible for monitoring the surveillance cameras. All camera issues are reported to and serviced by Armed Security Services. The individual assigned to the monitor station has a monitor to view the cameras, however, does not have access to review incidents. The access is restricted to all staff with the exception of the Facility Administrator and Operations Supervisor. The zero-tolerance signs are displayed in the monitor station for staff and PREA information is provided to visitors in both English and Spanish.

Main Hallway: The main hallway dayroom had a telephone for the residents with the PREA signs displayed in both English and Spanish, six TDCJ PREA numbers and hotlines, and the Purple Door 24-hour Sexual Assault Crisis Hotline. The PREA Audit notification was posted and dated 2/8/19. The dayroom had the PREA signs displayed in a large frame in both English and Spanish.

A-dorm was observed during the site review with a capacity of 32 residents, the female staff verbally made the announcement of a female entering the dorm. The dayroom had a television, one camera located in the corner of the area providing coverage of the dayroom. The PREA signs were displayed in both English and Spanish to include the PREA auditor notice and Purple door information.

D-dorm was an addition in 2007 to the CCTC. Female staff verbally made the announcement of a female entering the dorm prior to walking in the dorm during the site review. There was one camera in the dayroom and no security mirrors. The dorm is an open area and the auditor had a clear view of the area with no blind spots in sight. The dayroom lights were on with clear visibility and the area was clean. A and D dorm restrooms have a total of nine showers with full shower curtains and seven toilets with full doors providing adequate privacy from the opposite gender staff. The restrooms and showers had the PREA signs displayed in a large frame in both English and Spanish for easy visibility. The shower area had one handicap shower and the restroom had one handicap stall. The dayroom had a telephone for the residents with the PREA signs displayed in both English and Spanish, six TDCJ PREA numbers and hotlines, and the Purple Door 24-hour Sexual Assault Crisis Hotline. The PREA Audit notification was posted and dated 2/8/19. The dayroom had the PREA signs displayed in a large frame in both English and Spanish. The dorm had a television for the residents. The auditor opened one closet area which secured the air condition unit with staff limited access to keys and good lighting.

Main building was observed to have five showers with the full shower curtains and five restroom stalls with full doors for privacy. The laundry room had one camera, four washers, two dryers with PREA signs displayed and locked by 10:00 pm. The main building showers and restrooms are specifically for B and C dorms.

B-dorm had a capacity of 38 residents, the female staff verbally made the announcement of a female entering the dorm. There was one camera in the dayroom and no security mirrors. The dorm is an open area and the auditor had a clear view of the area with no blind spots in sight. The dayroom lights were on with clear visibility and the area was clean. The dayroom had a telephone for the residents with the PREA signs displayed in both English and Spanish, six TDCJ PREA numbers and hotlines, and the Purple Door 24-hour Sexual Assault Crisis Hotline. The PREA Audit notification was posted and dated 2/8/19. The dayroom had the PREA signs displayed in a large frame in both English and Spanish. The shower and restrooms for B dorm are in the main building hallway.

C-dorm had a capacity of 38 residents, the female staff verbally made the announcement of a female entering the dorm. There was one camera in the dayroom and no security mirrors. The dorm is an open area and the auditor had a clear view of the area with no blind spots in sight. The dayroom lights were on with clear visibility and the area was clean. The dayroom had a telephone for the residents with the PREA signs displayed in both English and Spanish, six TDCJ PREA numbers and hotlines, and the Purple Door 24-hour Sexual Assault Crisis Hotline. The PREA Audit notification was posted and dated 2/8/19. The dayroom had the PREA signs displayed in a large frame in both English and Spanish to include grievance notice & Purple door. The shower and restrooms for C dorm are in the main building hallway. The main hallway dayroom a large display with the PREA signs, Purple door notice, notice of audit in both English and Spanish. There was one camera in the main hallway dayroom. The dayroom had a total of three phones with the purple door information posted to include PREA signs, third-party notice and Facility Director information. The main hallway dayroom had an area by the phone with grievance forms and other information accessible to the resident as needed. The resident could pick up any form at any time without having to ask anyone for a grievance.

The Resident Dining area had two cameras and a payphone with the PREA information displayed for easy access. The Food Service department had one camera with two food service cooks assigned. The auditor observed the freezer which had one security mirror positioned to capture any blind spots and the pantry for dry goods was observed during the site review. There were no resident assigned to the food service department. The second dayroom in the main hallway is utilized for visitation on the weekends. The PREA signs, Third-Party reporting and Facility Director information are posted for the residents and family members.
The auditor observed the following offices during the site review: Human Resources, medication room, quality assurance, Operations Supervisor, Staff restrooms/UA's, fire alarm systems room and the Facility Director's office. The auditor observed the PREA signs and notice of audit posted. The facility does not have a basement or an attic. The recreation area is outside with basketball rims and a court, however, does not have urinals. The residents return to their dorms for restroom use. Strip searches are prohibited on the facility. The auditor did not identify any visible blind spots on the recreation yard.

Residents Interviews

The auditor conducted residents' interviews on 4/2/19 with one resident respectfully declining the interview. Based on the resident's population size of 130 on the first day of the onsite portion of the audit, the PREA auditor handbook specifies that a minimum of 20 residents' interviews is required. The auditor is required to interview 10 random residents and 10 targeted resident interviews. The auditor selected a larger portion and a geographically diverse sample of random male residents for the audit process to include housing units by selecting the first and tenth of every housing unit. The Facility Director and other staff facilitated interviews of all residents in a private setting. The auditor conducted the following number of resident interviews during the onsite phase of the audit. T

Category of Residents	Interviews Conducted
Random Residents (Total)	12
Targeted Residents (Total)	8
Total Residents Interviewed	**20**
Breakdown of Targeted Resident Interviews:	
• Youthful residents	0 (no youthful residents assigned)
• Residents with physical disability	1
• Residents who are blind • deaf • hard of hearing	0 (no blind residents) 0 (no deaf residents) 1

• Resident who are LEP	2
• Residents with a cognitive disability	1
• Residents who identify as lesbian, gay, or bisexual	2
• Residents who identify as transgender or intersex	0 (there were no residents identified as transgender or intersex for interviews)
• Residents in segregated housing for high risk of sexual victimization/suffered prior abuse	0
• Residents who reported sexual abuse	0
• Residents who reported sexual victimization during risk screening	1
(Of the 130 population 8 residents met the targeted population) Total:	8

Residents were interviewed in an office on an individual basis with privacy and sufficient time. The residents were interviewed using the Department of Justice protocol interview questions generally and specifically targeting their knowledge of reporting mechanisms available for residents to report sexual abuse and sexual harassment. The residents interviewed were well informed about the PREA reporting process, their rights to be free from sexual abuse, and how to report sexual abuse or sexual harassment. One residents respectfully declined the interview. The facility director provided the auditor with a complete list of residents by housing, DOB, sex, race, admission date and residents meeting the targeted category. The auditor made a random selection from each housing unit to include a geographical selection of male residents.

The auditor made the random selection of staff to include all shifts, monitors, supervisory staff, and department heads including both male and female staff. The facility had a total of 10 volunteers, two volunteers were selected and interviewed telephonically because they were not volunteering on the day of the audit. The facility did not have any contractors and no interviews were conducted.

The auditor conducted the staff interviews on 4/1/19 and 4/2/19 with no staff refusals. Staff interviews were conducted in a private setting in the administration building in a separate office on an individual basis (previous interviews conducted included one agency head or designee and one agency PREA coordinator). The auditor conducted the following interviews with facility staff during the onsite phase of the audit:

Category of Staff	Interviews Conducted
Random Staff (total)	10
Specialized Staff (total)	10
Total Staff Interviewed	**20**
Breakdown of Specialized Staff Interviews:	
• Medical and mental health staff	0 (no mental health staff assigned) (new nurse in training)
• Non-medical staff involved in cross-gender strip searches	0
• Human resource staff	1
• SANE staff (telephonic interview offsite hospital)	1
• Volunteers and Contractors who have contact with residents	2 (2 Volunteers/0 Contractors)
• Investigative staff	1

• Staff who perform screening for risk of victimization	1
• Incident review team	1
• Designated staff member charged with monitoring retaliation	1
• First responder, security staff, non-security staff	1
• Intake staff	1
Total Random Staff:	10

The facility director provided the auditor with a list of employees with their full name, title and rank who filled specialized staff categories for interview planning to include a complete listing of staff with schedules for all employees. The auditor randomly selected names for the interviews for each category. All specialized and random staff interviews were conducted in private in the administrative building.

Document Sampling and Review

The facility provided the auditor with a list of documents through a secured website that included: Audit notices, PREA files, residents who reported sexual abuse, PREA log, residents housing roster, sexual victimization roster, policies, PREA audit questionnaire, employee list, and supporting documentation.

Name of Record	**Number Reviewed**
Employee Files/Training/Background (40)	20
Volunteer /Contractor	2V/1C
Resident Files (130)	20
Specialized training	2
Investigative File	3
Total Files	47

Employee Files: The auditor reviewed a total of 20 employee files with training records and background checks that corresponded with employees interviewed during the onsite phase of the audit. The auditor selected the 20 employee files from the same list of the 40 reviewed files with a random selection in no specific order. The auditor attempted to review a few monitors, department heads and volunteers. The facility provided the auditor with information regarding one contractor during the 12 months preceding the audit. The auditor reviewed the contractor information and PREA training. The contractor was on longer assigned to the facility during the onsite PREA audit, therefore, the auditor did not conduct any contractor interviews.

Resident Files: The auditor reviewed a total of 20 files which corresponded with the resident interview list of 20 residents during the onsite phase of audit meeting all categories.

Investigation Files: The auditor reviewed three sexual abuse allegations for the past twelve months. One of the investigations was Staff-on-Resident and one investigation was Residents. The facility administrator provided the investigations to the auditor on the first day of the audit for review. The auditor reviewed two investigations provided by the facility to include an interview with the facility investigator. The auditor reviewed on case that was currently open and pending. The auditor reviewed the administrative investigation records, including retaliation monitoring for alleged victims, for incidents of sexual abuse and sexual harassment that were reported in the past 12 months immediately preceding the audit.

The facility had two investigators who are responsible for conducting all administrative investigations and all criminal investigations are forwarded to the local police department for further investigation. The facility reviewed the Grievances for the past 12 months and the facility had no grievances related to PREA. There were no records of criminal investigations pending during the audit. The investigation dispositions are shown below:

Description	Status	Criminal Case/Disposition	Criminal/Administrative
1. Resident-on-Resident	Unfounded	No case opened	Administrative
2. Staff-on-Resident	Unfounded	No case opened	Administrative
3. Staff-on-Resident	Pending/Open Case	Referred to CCPD	Administrative

Exit Meeting:
On the last day of the audit, an exit meeting was held on 4/2/19 to discuss the overall audit process with the Facility Director/PREA Manager. The auditor discussed the review of the pre-audit process to include the post notice of upcoming audit, communication with the community-based victim advocates, and auditor review of submitted agency facility questionnaire, policies and procedures. The auditor provided a discussed several positive practices observed during the audit Site Review and interviews with staff and residents. The auditor also discussed missing documentation and corrective action that would be required by the facility noted during the review process. The facility was prepared with documentation supporting each PREA standard. The on-site audit consisted of the site review, additional document review, to include staff and residents' interviews. The Post Audit included the auditor compliance tool, review of policies/procedures, review of documentation and data. The auditor noted that this audit was the re-certification for the facility.

The first PREA audit for CCTC was conducted by PREA auditor Barbara Jo Denison on April 4-5, 2016. The previous auditor determined the CCTC exceeded three standards, met 33 standards and the other three were non-applicable. During the second audit cycle, the audit was conducted by Noelda Martinez, single auditor on April 1 & 2, 2019. In addition, the auditor determined the facility exceeded three standards which included 115.211, 115.215, & 115.254, due to the exceptional documentation provided including observed practice and awareness made throughout the facility of the zero-tolerance of sexual abuse & sexual harassment. 115.405 Audit appeals. (a) An agency may lodge an appeal with the Department of Justice regarding any specific audit finding that it believes to be incorrect. Such appeal must be lodged within 90 days of the auditor's final determination. The Agency's Right to Appeal Standard 115.405 provides agencies with the option to appeal any findings of an audit that they believe are incorrect. The auditor who issued the findings under appeal has no role in the appeal process other than to provide documentation of his or her work or answer questions upon request by DOJ.

Facility Characteristics

The auditor's description of the audited facility should include details about the facility type, demographics and size of the resident, resident or detainee population, numbers and type of staff positions, configuration and layout of the facility, numbers of housing units, description of housing units including any special housing units, a description of programs and services, including food service and recreation. The auditor should describe how these details are relevant to PREA implementation and compliance.

The Corpus Christi Transitional Center, owned and operated by CoreCivic, is located at 1515 North Tancahua, Corpus Christi, TX 78401. The current capacity was 130 beds for housing adult male residents. The auditor did not encounter any issues with facility administration or PREA management for the completion of the audit. CoreCivic has a page on their website (http://www.corecivic.com/the-prison-rape-elimination-act-of-2003-prea) dedicated to PREA which includes their zero-tolerance policy reporting requirements, and reporting information. Corpus Christi Transitional Center (formerly Reality Ranch) is a halfway house and residential treatment program located at 1515 N. Tancahua in Corpus Christi, Texas. The Corpus Christi TC was acquired in November 2012 and contracts with the Texas Department of Criminal Justice to provide Halfway House and Therapeutic Treatment programs. The program is licensed to provide drug and alcohol treatment by the Texas Department of State Health Services. The Corpus Christi TC provides halfway house residents with case management, employment placement and reintegration programs, as well as 3 meals per day. Public transportation is located close to the facility. When residents are unable to take public transportation, the company provides transportation to employment, employment searches, medical and dental as well as any additional off-site programming services. They deliver proven and innovative practices in settings that help people obtain employment, successfully reintegrate into society and keep communities safe.

The facility Demographics:

Designed facility capacity Current population (4/1/19)	158 130
Population	Adult Males
Contracts	TDCJ
Resident Custody Level	Treatment Center- Intensive and Residential
Age Range of Residents	18-75
Full-time staff	40
PREA Manager	1
Cameras	29

Video Surveillance:

The facility provided the auditor with number of surveillance cameras on the facility. The facility had a total of 29 cameras and are only viewed by the designated monitoring staff with a retention of 30 days. The cameras are serviced by Alarm Security Services. The auditor observed 29 surveillance cameras positioned in administration conference room, laundry, housing dorms A, B, C, D, food service/visitation, and the monitor station where all pat-searches are conducted directly under video surveillance by same gender monitor/staff.

Mission Statement:

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

Summary of Audit Findings

*The summary should include the number of standards exceeded, number of standards met, and number of standards not met, **along with a list of each of the standards in each category**. If relevant, provide a summarized description of the corrective action plan, including deficiencies observed, recommendations made, actions taken by the agency, relevant timelines, and methods used by the auditor to reassess compliance.*

***Auditor Note:** No standard should be found to be "Not Applicable" or "NA". A compliance determination must be made for each standard.*

Number of Standards Exceeded: Click or tap here to enter text.

115.211,115.215, 115.254

Number of Standards Met: Click or tap here to enter text.

115.212, 115.213, 115.216, 115.217, 115.221, 115.222, 115.231, 115.232, 115.233, 115.234, 115.235, 115.241, 115.242, 115.251, 115.252, 115.253, 115.254, 115.261,115.262, 115.263, 115.264, 115.265, 115.266, 115.267, 115.271, 115.272, 115.273, 115.276, 115.277, 115.278, 115.282, 115.283, 115.286, 115.287, 115.288, 115.289

Number of Standards Not Met: -

-

Summary of Corrective Action (if any)

The first PREA audit for CCTC was conducted by PREA auditor Barbara Jo Denison on April 4-5, 2016. The previous auditor determined the CCTC exceeded three standards, met 33 standards and the other three were non-applicable. During the second audit cycle, the audit was conducted by Noelda Martinez, single auditor on April 1 & 2, 2019. In addition, the auditor determined the facility exceeded three standard which included 115.211, 115.215, & 115.254, due to the exceptional documentation provided including observed practice and awareness made throughout the facility of the zero-tolerance of sexual abuse & sexual harassment.

PREVENTION PLANNING

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

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

115.211 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? ☒ Yes ☐ No

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

115.211 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator? ☒ Yes ☐ No

- Is the PREA Coordinator position in the upper-level of the agency hierarchy? ☒ Yes ☐ No

- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities?
  ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:
Primary:
A. Policy 14-2 CC Sexual Abuse Prevention and Response
Secondary:
1. FSC Organizational Chart- Correctional Programs Division
2. Appointment Memo-Senior Director PREA
3. Job Description-Senior Director, PREA Programs and Compliance
4. Organizational Chart-Corpus Christi Transitional Center

Interviews:

a. PREA Coordinator

Site Review Observations:

a. PREA signage throughout the facility
b. Cross-gender announcements observed in A dorm, B dorm, C dorm, D dorm and E dorm
c. Shower curtains and doors on individual restroom stalls

Findings:

115.211 (a) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 1 of 34 section A; mandated zero-tolerance policy towards all forms of sexual abuse and sexual harassment. Sexual activity between residents/employees/contractors regardless of consensual status is strictly prohibited and subject to administrative sanctions and criminal prosecutions.

115.211 (b) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 2 of 34 section B. The agency has a designated Senior Director for the PREA Program and Facility Director responsible for the PREA program. The PREA manager has sufficient time to complete all PREA duties and responsibilities. The PREA coordinator/manager is the Facility Director and stated during the interview that she that she had sufficient amount of time to complete her PREA responsibilities.

Corrective Action: The auditor recommends no corrective action.

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

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

115.212 (a)

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

115.212 (b)

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents OR the response to 115.212(a)-1 is "NO".) ☐ Yes ☐ No ☒ NA

115.212 (c)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Findings: CoreCivic is a private provider and does not contract with other agencies for the confinement of those in their care.

Corrective Action: The auditor recommends no corrective action.

Standard 115.213: Supervision and monitoring

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

115.213 (a)

- Does the agency develop for each facility a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No

- Does the agency document for each facility a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the physical layout of each facility in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the composition of the resident population in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the prevalence of substantiated and unsubstantiated incidents of sexual abuse in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration any other relevant factors in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

115.213 (b)

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

115.213 (c)

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

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

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:
Primary:
1. Policy 14-2 CC Sexual Abuse Prevention and Response
2. General Order Post Order 00

Secondary:
1. 2018 Annual PREA Staffing Plan Assessment
2. List of Cameras
3. 2018 Operational Staffing pattern
4. 2018 PREA Statistics

Interviews:
a. Director or Designee
b. PREA Coordinator

Findings:
115.13 (a). Policy 14-2 CC Sexual Abuse Prevention and Response for Corpus Christi Transitional Center describes on pg. 9 of 31; CCTC staffing plan reviewed, & 29 surveillance cameras. The interview with Facility Director determined that the staffing plan is reviewed annually by the Senior PREA Director, and PREA Coordinator for all staffing issues to assess staffing levels for the protection of residents of sexual abuse, review of surveillance cameras for possible blind spots and sexual abuse incidents and locations, to include documentation of staffing reviews. The staffing percentage was at 100%. The staffing level review also includes physical plant, programs, laws, all sexual abuse incidents, threat levels, good correctional practices, contract and population ratio. There were no issues of non-compliance. The PCM stated that she was part of the staffing annual review and that CoreCivic representative was involved, PREA Director, and Facility Director were responsible for the assessment of the staffing compliance with input and communication for the overall safety of the sexual safety of the resident population.
115.13 (b). The staffing plan was reviewed for a 12-month period with no required deviations. The facility was at 100% staffing. The Facility Director stated that if a staffing issues occurs; the Facility Director will be contacted for additional staff for PREA safety if required. The PREA Coordinator stated that she was part of the Annual PREA staffing plan assessment once a year or as needed including the facility custody levels and population, patterns, video monitoring, supervision, locations, shifts, staff, all sexual abuse reports etc. These reviews are signed by the PCM, Facility Administrator, and Vice President of Facility Operations.
115.13 (c). Policy 14-2 CC Sexual Abuse Prevention and Response for Corpus Christi Transitional Center describes on pg. 9, Section D. The auditor observed the staffing plan for 2018. The PREA Coordinator stated that she was part of the Annual PREA staffing plan assessment once a year or as needed including the facility custody levels and population, patterns, video monitoring, supervision, locations, shifts, staff, all sexual abuse reports etc. These reviews are signed by the PCM, Facility Administrator, and Vice President of Facility Operations.

Corrective Action: The auditor recommends no corrective action.

Standard 115.215: Limits to cross-gender viewing and searches

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

115.215 (a)

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

115.215 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches of female residents, except in exigent circumstances? (N/A if less than 50 residents)
  ☐ Yes ☐ No ☒ NA

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

115.215 (c)

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

- Does the facility document all cross-gender pat-down searches of female residents?
  ☒ Yes ☐ No

115.215 (d)

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

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

115.215 (e)

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

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

115.215 (f)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:
Primary:
1. Policy 14-2 CC Sexual Abuse Prevention and Response
2. 5-1B Notification to Administration

Secondary:
1. Training: Offender pat search DVD, Training Attendance Roster
2. Section 206 of Client Handbook (d)
3. Search Lesson Plan (f)

Interviews:
1. Non-Medical staff (involved in cross-gender strip or visual searches) No medical staff employed.
2. Random Sample of Staff
3. Random Sample of Residents (No female residents assigned to the facility, male population only).
4. Transgender/Intersex Residents (No Transgender/Intersex assigned at the facility during the site review).

Site Review Observations:
During the site review, the auditor observed the housing units from A, B, C, D and E dorm had privacy in the shower and restroom area. The dorms had separate showers with full shower curtains and privacy from cross-gender viewing; The restrooms were individual stall with full doors for privacy with no cross-gender viewing.

The PREA signs are displayed in both English and Spanish. The female staff announce themselves by verbally saying, female in the dorm in a loud tone. The showers and restrooms for the male residents in all areas of the facility provide privacy from cross-gender viewing. The residents interviewed stated that the female employees do not walk into the shower or restroom areas at all. The facility provides a good practice of giving the male residents full privacy. Strip searches are prohibited and not conducted at the facility. The residents stated that pat-searches were conducted upon returning from work in the front check-in area by male staff in front of a camera. The audit notice & zero tolerance signs were observed by the auditor in every housing dorm in both English and Spanish to include the restrooms and shower areas. It was a large display of PREA signs visible to all the residents. There were restroom stalls with doors preventing cross-viewing and the overall safety of the residents. There were no urinals on the recreation yard, residents return to their housing.

Finding:
115.215 (a). Policy 14-2 CC Sexual Abuse Prevention and Response for CCTC on pg. 14, describing Search and Observation which includes cross-gender searches. CoreCivic personnel are not authorized to conduct physical searches of body cavities for residents. Body Cavity Searches are not authorized at CoreCivic facilities and will not be conducted by CoreCivic personnel without the prior approval of the Vice President, Operations. The CCTC did not conduct any cross-gender strip or cross-gender visual body cavity searches of residents in the past 12 months for any of the residents. There were no exigent circumstances or performed by non-medical staff in the past 12 months. The pat-searches are conducted by the same gender staff.
115.215 (b). Policy 14-2 CC Sexual Abuse Prevention and Response for CCTC on pg. 14, describing Search and Observation which includes cross-gender searches. The CCTC does not house female residents at the facility. Random staff interviews with both male and female staff determined that strip searches are prohibited. The random interviews with residents determined that they are not strip searched and same gender staff perform pat-searches.
115.215 (c). Policy 14-2 CC Sexual Abuse Prevention and Response for CCTC on pg. 14, describing Search and Observation which includes cross-gender searches. The CCTC did not conduct any cross-gender strip or cross-gender visual body cavity searches of residents in the past 12 months. There were no exigent circumstances or performed by non-medical staff in the past 12 months. Random video footage was observed on 4/1/19 in the monitor station for spot checks of pat-down searches of male residents. The facility has a strip search log in place, however, there have been no documented cross-gender pat down searches or strip searches of male residents (referencing cross-gender visual body cavity searches).
115.215 (d). The facility the Policy 14-2 Sexual Abuse Prevention and Response on page 14 of 34 Section K. The outlines references the residents may shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstance (that is unforeseen circumstances that require immediate action in order to combat a threat to security or institutional order) or when such viewing is incidental to routine cell/living quarter checks. Employees of the opposite gender must announce their presence when entering a residents housing unit. Spot checks of the surveillance cameras in monitor station were observed in male housing units with no opportunity for incidental viewing. The policy requires staff of the opposite gender to knock and announce their presence when entering a residents housing unit. The auditor observed these announcements from both male and female staff when entering the dorms on 4/1/19 and 20 out of 20 random interviews determined that male/female monitor/staff made the verbal announcement of the opposite gender for resident privacy prior to entering the dorm. 18 out of the 20 resident random interviews stated that male/female staff made the announcements prior to entering the dorm and that they had privacy from the opposite gender staff.
The other two responses were vague with a yes gesture. The auditor observed both male and female staff make the opposite gender announcements verbally by saying female in the dorm throughout the site review.
115.215 (e). 14-2 CC Sexual Abuse Prevention and Response on page 14 of 34 section K prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. There have been no intersex or transgender searches in the past 12 months.

115.215 (f). The percent is at 100% of all security staff who 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. CoreCivic provides all employees with additional training all all types of Searches, annual in-service requiring Search procedures. 10 of 10 random staff interviews stated that they attend training once a year.

Corrective Action: The auditor recommends no corrective action.

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

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

115.216 (a)

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.) ☒ Yes ☐ No

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

- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision? ☒ Yes ☐ No

115.216 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient? ☒ Yes ☐ No

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

115.216 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.264, or the investigation of the resident's allegations? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:
Primary:
1. Policy 14-2 CC Sexual Abuse Prevention and response
2. Resident Handbook-PREA (English/Spanish)
3. Memo: Interpreter Services

Secondary:
1. Language Line-Interpreter Services Instructions to Staff
2. 14-02AA-CC Preventing Sexual Abuse and Misconduct Handout & TDCJ PREA (English/Spanish)
3. Photo of PREA Poster, CoreCivic PREA Resident Poster, and Resident Reporting Poster
4. TTY Machine for Hearing Impaired & Resident Telephone
5. Photo of the PREA Training Multi-Language DVD

Interviews:
1. Agency Head
2. Residents with disabilities or who are LEP
3. Random Staff

Site Review Observations:
1. Information posted in both English/Spanish
2. Staff interpreter list/TTY machine/Language Line

Findings:
115. 216 (a). Policy 14-2 CC Sexual Abuse Prevention and Response on page 13 of 34 Section 5. a. establishing 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. The facility has contracts for the following: Language Line Interpreter, Contract Usage of Language Line Services and the TTY Machine for Hearing Impaired & Resident Telephone. Twenty out of 40 employee files were reviewed for the residents with disability training. LEP residents stated that several staff spoke Spanish and they hand no problems communicating.

• Residents with physical disability	1
• Residents who are blind • deaf • hard of hearing	0 (no blind residents) 0 (no deaf residents) 1
• Resident who are LEP	2
• Residents with a cognitive disability	1

115.216 (b). Policy 14-2 CC Sexual Abuse Prevention and Response on page 14 of 34 Section b. describes the established procedures to provide residents with limited English proficiency equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The facility has contracts for the following: Language Line Interpreter, Line Services and the TTY

Machine for Hearing Impaired & Resident Telephone. Twenty-out of 40 employee files were reviewed for the residents with disability training. LEP residents stated that several staff spoke Spanish and they hand no problems communicating. The agency head interview determined that CoreCivic corporate office aids facilities that enable them to locate potential vendors and/or agencies that would provide support services for residents with disabilities. The agency maintains a comprehensive contract with the Language Line and some even have an MOU with organizations in the local communities to provide translation services when needed. TTY phones are provided, and arrangements are also made to assist those residents who are blind. Residents with disabilities or who are limited English proficient stated that the means of communication were provided at the facility. The site review determined that the PREA signs and other postings were displayed in both English and Spanish.

115.216 (c). Policy 14-2 CC Sexual Abuse Prevention and Response on page 14 of 34 Section c. prohibits use of resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.264, or the investigation of the resident's allegations. There were no documentation of resident interpreters used in the past 12 months. The facility has contracts for the following: Language Line Interpreter, Language Line Services and the TTY Machine for Hearing Impaired & Resident Telephone. Twenty out of 40 employee files were reviewed for the residents with disability training. LEP residents stated that several staff spoke Spanish and they hand no problems communicating.

Corrective Action: The auditor recommends no corrective action.

Standard 115.217: Hiring and promotion decisions

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

115.217 (a)

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

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

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

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

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

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

115.217 (b)

- Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents? ☒ Yes ☐ No

115.217 (c)

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

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

115.217 (d)

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

115.217 (e)

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

115.217 (f)

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

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

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

115.217 (g)

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

115.217 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:
Primary:
1. Primary 14-2 CC Sexual Abuse Prevention and Response

Secondary:
1. Employee: 14-02H CC Self-Declaration of Sexual Abuse/Sexual Harassment, Background check, Employment verification
2. Contractor: 14-02H CC Self-Declaration of Sexual Abuse/Sexual Harassment, Memo about background, Training Acknowledgement
3. Promotion-14-02H CC Self-Declaration of Sexual Abuse/Sexual Harassment
4. Employment Reference Check (applicant) and 3-20-2B PREA Questionnaire for prior Institutional Employers
5. Spreadsheet with 5-year background check

Interviews:
1. Administrative (Human Resources) Staff

Site Review Observation:

<u>Document Sampling and Review</u>

The facility provided the auditor with a list of documents through a secured website that included: Audit notices, PREA files, residents who reported sexual abuse, PREA log, residents housing roster, sexual victimization roster, policies, PREA audit questionnaire, employee list, and supporting documentation.

Name of Record	Number Reviewed
Employee Files/Training/Background (40)	20
Volunteer	2V/1C
Resident Files (130)	20
Specialized training	2
Investigative File	3
Total Files	47

Employee Files: The auditor reviewed a total of 20 employee files with training records and background checks that corresponded with employees interviewed during the onsite phase of the audit. The auditor selected the 20 employee files from the same list of the 40 reviewed files with a random selection in no specific order. The auditor attempted to review a few monitors, department heads and volunteers. The facility provided the auditor with information regarding one contractor during the 12 months preceding the audit. The auditor reviewed the contractor information and PREA training. The contractor was on longer assigned to the facility during the onsite PREA audit, therefore, the auditor did not conduct any contractor interviews.

Resident Files: The auditor reviewed a total of 20 files which corresponded with the resident interview list of 20 residents during the onsite phase of audit meeting all categories.

CCTC did not have any disciplinary or terminations for staff regarding abuse or sexual harassment. The allegations of staff sexual misconduct were determined to be unfounded.

Findings:
115.217 (a) Policy 14-2 CC Sexual Abuse Prevention and Response on page 5 of 34 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 in paragraph (a)(2) of this section. A review of 20 of 40 employee files determined proper criminal record background checks have been conducted and questions regarding past conduct.
115.217 (b) Policy 14-2 CC Sexual Abuse Prevention and Response on page 5 of 34 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. The Human Resource Manager interview determined that all staff prior incidents of a sexual nature in the decision to hire.
115.217 (c) Policy 14-2 CC Sexual Abuse Prevention and Response on page 5 of 34 section B, requires that before it hires any new employees who may have contact with residents, it (a) conducts criminal background record checks, and (b) consistent with federal, state, and local law, makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. The facility did not have any new hired individuals in the past 12 months. The HR interview determined that the facility performs background checks all employees to include newly hired, contractors or promotions.

115.217 (d) Policy 14-2 CC Sexual Abuse Prevention and Response on page 5 of 34 section B, requires that a criminal background record check be completed before enlisting the services of any contractor who may have contact with residents. In the past 12 months, the number of contracts for services where criminal background record checks were conducted on all staff covered in the contract who might have contact with residents: 0.
115.217 (e) Policy 14-2 CC Sexual Abuse Prevention and Response on page 5 of 34 section B, 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.
115.217 (f) Policy 14-2 CC Sexual Abuse Prevention and Response on page 5 of 34, The HR manager stated during the interview that the facility shall also impose upon employees a continuing affirmative duty to disclose any such misconduct.
115.217 (g) Policy 14-2 CC Sexual Abuse Prevention and Response on page 5 of 34, states that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.
115.217 (h) Policy 14-2 CC Sexual Abuse Prevention and Response on page 6 of 34, 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. The HR manager stated that all protocols would be followed prior to releasing any information according to policy.

Corrective Action: The auditor recommends no corrective action.

Standard 115.218: Upgrades to facilities and technologies

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

115.218 (a)

- If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.)
  ☐ Yes ☐ No ☒ NA

115.218 (b)

- If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.)
  ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:
Primary:
1. Policy 14-2 CC Sexual Abuse Prevention and Response

Secondary:
1. Note regarding upgrade to cameras
2. Security Camera locations
3. 2018 PREA Staffing Plan Assessment
4. 7-1B, PREA Physical Plant Considerations

Interviews:
1. Agency Head
2. Director or Designee

Site Review Observations:
The facility provided the auditor with a surveillance camera report of all the locations describing the types of cameras. The cameras are monitored from the monitor station. The Alarm Security Services provides technical assistance and operational support to video surveillance, video equipment/production, and technology. The maintenance assists in maintaining and repairing existing surveillance systems, as well as providing technical evaluation for augmentation and improvements. The auditor observed 29 surveillance cameras positioned in the administration conference room, Area between main building and E dorm, North side of the property, dumpster view, North side of property; B dorm fire exit ramp, West side of property area between dorms F and D; mop station, view of entrance, main building, parking lot, front porch, interior view of monitor station to monitor residents and staff movement. The recordings are maintained for 30 days. There were an additional 16 surveillance cameras added to the facility in 2018 which included E dorm, medication office, B dorm, receptionist office, laundry room, kitchen, dining hall, dayroom, group room C, C dorm, A dorm, Dinner hall, F dorm and main building hallway to dorms.

Findings:
115.218 (a) Policy 14-2 Sexual Abuse Prevention and Response on page 33 of 34 section V, Interviews with the agency head determined there have been no substantial expansions or modifications since 2012.
115.218 (b) Policy 14-2 Sexual Abuse Prevention and Response on page 33 of 34 section 2, The interview with the Facility Director stated that 16 additional surveillance cameras were added in 2018 throughout the center.

Corrective Action: The auditor recommends no corrective action

RESPONSIVE PLANNING

Standard 115.221: Evidence protocol and forensic medical examinations

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

115.221 (a)

- If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.221 (b)

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.221 (c)

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate? ☒ Yes ☐ No

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

- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? ☒ Yes ☐ No

- Has the agency documented its efforts to provide SAFEs or SANEs? ☒ Yes ☐ No

115.221 (d)

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

- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? ☒ Yes ☐ No

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

115.221 (e)

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

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

115.221 (f)

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

115.221 (g)

- Auditor is not required to audit this provision.

115.221 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.221(d) above.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:
Primary:
1. Policy 14-2 CC Sexual Abuse Prevention and response

Secondary:
1. PREA Investigator Training Certificates
2. Overview of PREA Investigator Training Curriculum
3. Memorandum of Understanding-The Purple Door
4. Memorandum of Understanding-Corpus Christi Police Dept (Draft/attempts)

Interviews:
1. SANE/SAFE Staff (telephonic interview offsite location/hospital)
2. Random Staff
3. PREA Coordinator
4. Residents who reported a sexual abuse (no residents in this category for interviews during onsite audit)

Site Review Observations:
The auditor reviewed the Memorandum of Understanding between CoreCivic of Tennessee, LLC/Corpus Christi Transitional Center (CCTC) and the Purple Door. The document establishes guidelines for the provision of victim services to residents in custody by and between Corpus Christi Transitional Center and Women's Shelter of South Texas D/B/A/ The Purple Door. The Purple door agrees to arrange for forensic examinations for resident victims of sexual abuse, such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs), follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. Provide a victim advocate, if requested by the victim; contact facility personnel and provide the identity of the victim advocate responding to the forensic exam. Provide 24-hour sexual abuse/assault crisis line number and the Purple Door mailing addresses that may be posted throughout the facility and in written resources given to residents. On 4/1/19, the 24-hour Crisis Hotline was tested by the auditor and was in good working condition, the representative stated that no calls had been received from the facility. On 4/1/19, the auditor contacted the SANE/SAFE nurse on-call, the process for a sexual assault was explained, and no other information was disclosed regarding the facility on that specific night. The residents interviewed by the auditor understood how to contact the rape crisis center directly at any time if needed. The Sexual Assault Services include crisis intervention and advocacy, available to adult survivors of stranger and non-stranger sexual assault at no charge 24-hours per day, 7 days per week, 365 days per year.

Findings:
115.221 (a) Policy 14-2 CC Sexual Abuse Prevention and Response page 10 of 34, facility is responsible for conducting administrative or criminal sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). The facility does not have an MOU with the Corpus Christi Police department. The

Facility Interview determined that the facility is working on establishing a good working rapport to obtain an MOU in the future.
Any and all criminal investigations are forwarded to the CCPD for further investigation according to the Interview with the Facility Director. 10 random staff interviews articulated their first responder duties and level of confidentiality.
115.221 (b) CCTC does not house youthful residents.
115.221 (c) Policy 14-2 CC Sexual Abuse Prevention and Response page 25 of 34 A. The SANE/SAFE exams are conducted offsite at the local Hospital. The facility offers all residents who experience sexual abuse access to forensic medical examinations without financial cost. The number of forensic medical exams conducted during the past 12 months: 0. The number of exams performed by SANEs/SAFEs during the past 12 months: 0.
The number of exams performed by a qualified medical practitioner during the past 12 months: 0.
115.221 (d) Policy 14-2 CC Sexual Abuse Prevention and Response page 25 of 34 B, the facility has an MOU with the Purple Door in Corpus Christi, TX.
115.221 (e) Policy 14-2 CC Sexual Abuse Prevention and Response page 25 of 34 C, the facility has an MOU with the Purple Door in Corpus Christi, TX. There were no residents onsite who reported sexual abuse for interviews during the audit.
115.221 (f) Policy 14-2 CC Sexual Abuse Prevention and Response page 25 of 34 D, the facility does not has an MOU with the Corpus Christi Police department.
115.221 (g) The facility does not has an MOU with the Corpus Christi Police department.
however, will forward all criminal investigations to CCPD.
115.221 (h) The Purple door agrees to arrange for forensic examinations for resident victims of sexual abuse. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs). Provide a victim advocate, if requested by the victim, and allow the victim advocate to provide emotional support, and accompany the victim through the forensic medical examination process and investigatory interviews. Provide a 24-hour sexual abuse/assault crisis line number ant the Purple Door mailing address that is posted throughout the facility and is provided in written resources to residents.
Corrective Action: The auditor recommends no corrective action.

Standard 115.222: Policies to ensure referrals of allegations for investigations

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

115.222 (a)

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

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

115.222 (b)

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

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

- Does the agency document all such referrals? ☒ Yes ☐ No

115.222 (c)

- If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? [N/A if the agency/facility is responsible for conducting criminal investigations. See 115.221(a).]
  ☒ Yes ☐ No ☐ NA

115.222 (d)

- Auditor is not required to audit this provision.

115.222 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:
Primary:
1. Policy 14-2 Sexual Abuse Prevention and Response
2. CC website information, http://www.corecivic.com/facilities/corpus-christi-transitional-center

Secondary:
1. Training Documents: PREA Overview Facilitator Guide and PREA Training Handout
2. 2018 Training Schedule (Pre-Service and In-Service)
3. Training Rosters-PREA Overview (Pre-Service and In-Service)
4. PREA Training Acknowledgement Form (Pre-Service and In-Service)

Interviews:

1. Agency Head
2. Investigative Staff

Site Review Observations:
Reviewed the sexual abuse investigations conducted at the facility for the past 12 months and interviewed the investigator to include a review of the specialized training.

Investigation Files: The auditor reviewed three sexual abuse allegations for the past twelve months. One of the investigations was Staff-on-Resident and one investigation was Residents. The facility administrator provided the investigations to the auditor on the first day of the audit for review. The auditor reviewed two investigations provided by the facility to include an interview with the facility investigator. The auditor reviewed on case that was currently open and pending. The auditor reviewed the administrative investigation records, including retaliation monitoring for alleged victims, for incidents of sexual abuse and sexual harassment that were reported in the past 12 months immediately preceding the audit.

The facility had two investigators who are responsible for conducting all administrative investigations and all criminal investigations are forwarded to the local police department for further investigation. The facility reviewed the Grievances for the past 12 months and the facility had no grievances related to PREA. There were no records of criminal investigations pending during the audit. The investigation dispositions are shown below:

Description	Status	Criminal Case/Disposition	Criminal/Administrative
3. Resident-on-Resident	Unfounded	No case opened	Administrative
4. Staff-on-Resident	Unfounded	No case opened	Administrative
5. Staff-on-Resident	Pending/Open Case	Referred to CCPD	Administrative

Findings:

115.222 (a) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 24 of 34. The interview with the facility head determined that all administrative or criminal investigation are completed for all allegations of sexual abuse and sexual harassment. The facility had seven investigations in the past 12 months. During the past 12 months, the number of allegations of sexual abuse and sexual harassment that were received: 2.
During the past 12 months, the number of allegations resulting in an administrative investigation: 2. During the past 12 months, the number of allegations referred for criminal investigation: 0.
115.222 (b) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 24 of 34, policy that requires that 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 investigative staff interviews determined that the facility does not have an MOU with the Corpus Christi Police Department, however, will refer all criminal investigations regarding criminal cases to CCPD.
115.222 (c) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 25 of 34.
115.222 (d) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 26 of 34, the facility does not has an MOU with the Corpus Christi Police department.
115.222 (e) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 26 of 34, the facility does not has an MOU with the Corpus Christi Police department.

Corrective Action: The auditor recommends no corrective action.

TRAINING AND EDUCATION

Standard 115.231: Employee training

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

115.231 (a)

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in confinement? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The common reactions of sexual abuse and sexual harassment victims? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? ☐ Yes ☐ No

115.231 (b)

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

- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? ☒ Yes ☐ No

115.231 (c)

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

- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? ☒ Yes ☐ No

- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? ☒ Yes ☐ No

115.231 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:
Primary:
1. Policy 14-2 CC Sexual Abuse Prevention and Response

Secondary:
1. Training Documents: PREA Overview Facilitator Guide and PREA Training Handout
2. 2018 Training Schedule (Pre-Service and In-Service)
3. Training Rosters-PREA Overview (Pre-Service and In-Service)

4. PREA Training Acknowledgement Form (Pre-Service and In-Service)

Interviews:

1. Random Staff

Site Review Observations:

Document Sampling and Review

The facility provided the auditor with a list of documents through a secured website that included: Audit notices, PREA files, residents who reported sexual abuse, PREA log, residents housing roster, sexual victimization roster, policies, PREA audit questionnaire, employee list, and supporting documentation.

Name of Record	Number Reviewed
Employee Files/Training/Background (40)	20
Volunteer	2V/1C
Resident Files (130)	20
Specialized training	2
Investigative File	3
Total Files	47

Employee Files: The auditor reviewed a total of 20 employee files with training records and background checks that corresponded with employees interviewed during the onsite phase of the audit. The auditor selected the 20 employee files from the same list of the 40 reviewed files with a random selection in no specific order. The auditor attempted to review a few monitors, department heads and volunteers. The facility provided the auditor with information regarding one contractor during the 12 months preceding the audit. The auditor reviewed the contractor information and PREA training. The contractor was on longer assigned to the facility during the onsite PREA audit, therefore, the auditor did not conduct any contractor interviews.

Resident Files: The auditor reviewed a total of 20 files which corresponded with the resident interview list of 20 residents during the onsite phase of audit meeting all categories.

Findings:

115.231 (a) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 6 of 34, trains all employees who may have contact with residents on the following matters 115.231 (a) 1-10. Twenty out of 40 employee training files were reviewed for compliance (1-10). Ten random staff interviews determined that they have received the training at least once a year. The random staff were asked about their training and questions regarding their duties and responsibilities.

115.231 (b) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 6 of 34, training is tailored to the gender of the residents at the facility. Twenty out of 40 employee training files were reviewed for compliance.

115.231 (c) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 7 of 34, the number of staff employed by the facility, who may have contact with residents, who were trained or retrained in PREA requirements 100%. The frequency with which employees who may have contact with residents receive refresher training on PREA requirements. 100%.

115.231 (d) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 8 of 34, Twenty files had the documentation of employee signatures or electronic verification signifying comprehension of the training.

Corrective Action: The auditor recommends no corrective action.

Standard 115.232: Volunteer and contractor training

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

115.232 (a)

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

115.232 (b)

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

115.232 (c)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:

Primary:

1. Policy 14-2 CC Sexual Abuse Prevention and Response

Secondary:

1. Volunteer File PREA Training Video
2. PREA Training and Zero Tolerance Policy Acknowledgement-Volunteer
3. Contractor Training Documents: PREA Overview Facilitator Guide and PREA Training Handout
4. PREA Training and Zero Tolerance Policy Acknowledgement-Contractor

Interviews:

1. Volunteer(s) and Contractor(s) who have contact with residents

Findings:

115.232 (a) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 8 of 34, All volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's policies and procedures regarding sexual abuse/harassment prevention, detection, and response. The auditor reviewed 2 Volunteers files who received the PREA volunteer training and 1 contractor who received the PREA training prior to the day of the audit. The facility provided the auditor with information regarding one contractor during the 12 months preceding the audit. The auditor reviewed the contractor information and PREA training. The contractor was on longer assigned to the facility during the onsite PREA audit, therefore, the auditor did not conduct any contractor interviews. The volunteer and contractor signed the PREA policy training acknowledgement and a self-declaration of sexual abuse/sexual harassment and Training Acknowledgement. The auditor interviewed two volunteers and the stated that they received the training and understood the reporting process and training requirements.

115.232 (b) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 8 of 34, 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 and notified of the agency's zero-tolerance policy. The volunteer and contractors signed the PREA policy training acknowledgement and a self-declaration of sexual abuse/sexual harassment. The auditor interviewed two volunteers and the stated that they have received the training and understand the reporting process and training requirements.

115.232 (c) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 8 of 34, maintains documentation confirming that volunteers/contractors understand the training they have received. The volunteer's and contractor files is the source to which the facility identifies the approval status of a volunteer. The facility provided the auditor with Acknowledgment of Volunteer Training and contractor training confirming compliance with the standard.

Corrective Action: The auditor recommends no corrective action.

Standard 115.233: Resident education

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

115.233 (a)

- During intake, do residents receive information explaining: The agency's zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No

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

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

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

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

115.233 (b)

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

115.233 (c)

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

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

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

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

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

115.233 (d)

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

115.233 (e)

- In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:

Primary:

A. Policy 14-2 Sexual Abuse Prevention and Response
B. Policy 14-1 Resident/Residents Rights

Secondary:

1. CoreCivic Brochures (English and Spanish)
2. PREA Multi-Language DVD, 'What You Need to Know"
3. Zero Tolerance Acknowledgement for Residents
4. Photos of PREA Posters, CoreCivic PREA Poster
5. Resident Handbook & Signed Resident Acknowledgement of Handbook
6. Memo Communication of Resident Education, Language Line Interpreter Instructions to Staff

Interviews:

1. Random Residents
2. Intake Staff

Site Review Observations:

During the facility site review, random residents were asked about their rights to be free from PREA and the reporting process. The facility had large display of PREA signs in both English and Spanish in all dorms.

Findings:

115.233 (a) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 13. The intake monitor was interviewed and stated that all residents receive zero-tolerance and PREA information immediately upon arrival. The number of residents admitted during past 12 months who were given this information at intake: 796. The PREA information is provided to the resident handbook, Resident video schedule showing Know your rights and the PREA video in both English and Spanish. The resident handbook in Chapter Eight, 801 PREA provides multiple ways report sexual abuse to include the Zero-Tolerance Signs, Staff, Residents, Family and Friends, PREA Ombudsman Office, Office of Inspector General, the Purple Door, TDCJ Ombudsman Coordinator, TDCJ Correctional Institutions Division, CID Ombudsman Office, PREA Hotline, Sexual Assault Hotline and agency

toll-free telephone number. The facility has an orientation verification that the resident signs upon completion of the PREA video, orientation video, and are given the opportunity to ask questions. The intake monitor ensure the handbook acknowledgement is signed, to include the Zero Tolerance Acknowledgement for Residents.

115.233 (b) The number of residents admitted during past 12 months who were given this information at intake: 8. All incoming residents received the PREA information. Intake staff interviews determined that the residents are assessed upon arrival and provided the information. 10 random residents said they remembered receiving the information and one resident said he didn't remember but knows how to report a sexual abuse.

115.233 (c) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 14. Intake staff stated that any resident requiring the language line, TTY or other services for effective communication would be provided immediately as needed.

115.233 (d) Resident PREA education is available in formats accessible to all residents, including those who are Limited English proficient, Deaf, Visually impaired, otherwise disabled, and Limited in their reading skills. The agency maintains documentation of resident participation in PREA education sessions.

115.233 (e) The PREA information is provided to the resident handbook, Resident video schedule showing Know your rights and the PREA video in both English and Spanish. The resident handbook provides multiple ways to report an abuse with clear instructions. The facility has an orientation verification that the residents sign upon completion to ensure every resident receives the PREA information.

115.233 The facility has the PREA information largely displayed in both English and Spanish for the resident population. The facility handbook has a section in the handbook in chapter eight which describes multiple ways to report a sexual abuse. The facility has an orientation verification that the residents sign upon completion of the PREA video, orientation video, and are given the opportunity to ask questions.

Corrective Action: The auditor recommends no corrective action.

Standard 115.234: Specialized training: Investigations

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

115.234 (a)

- In addition to the general training provided to all employees pursuant to §115.231, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA

115.234 (b)

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

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

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

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

115.234 (c)

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

115.234 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:

Primary:

A. Policy 14-2 CC Sexual Abuse Prevention and Response

Secondary:

1. PREA Investigator Training Curriculum
2. Facility PREA Investigator Certificates

Interviews:
1. Investigative Staff
2. Two files reviewed for Specialized training for Investigations

Site Review Observations:
The facility investigator was interviewed and explained his training to include the investigative process.
Investigation Files: The auditor reviewed three sexual abuse allegations for the past twelve months. One of the investigations was Staff-on-Resident and one investigation was Residents. The facility administrator provided the investigations to the auditor on the first day of the audit for review. The auditor reviewed two investigations provided by the facility to include an interview with the facility investigator. The auditor reviewed on case that was currently open and pending. The auditor reviewed the administrative investigation records, including retaliation monitoring for alleged victims, for incidents of sexual abuse and sexual harassment that were reported in the past 12 months immediately preceding the audit.

The facility had two investigators who are responsible for conducting all administrative investigations and all criminal investigations are forwarded to the local police department for further investigation. The facility reviewed the Grievances for the past 12 months and the facility had no grievances related to PREA. There were no records of criminal investigations pending during the audit. The investigation dispositions are shown below:

Description	Status	Criminal Case/Disposition	Criminal/Administrative
1. Resident-on-Resident	Unfounded	No case opened	Administrative
2. Staff-on-Resident	Unfounded	No case opened	Administrative
3. Staff-on-Resident	Pending/Open Case	Referred to CCPD	Administrative

Findings:
115.234 (a) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 7 section B. A review of the employment education and training record for the facility investigators meet the specialized training requirements. The investigators received the Specialized Training for investigators and PREA Investigation Protocols (Relias Learning).
115.234 (b) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 7 section B. The investigator training and PREA Investigation Protocols (Relias Learning) covers all the required trainings.
115.234 (c) The facility utilizes two Investigators on the facility for all sexual abuse investigations. All criminal cases will be referred to the Corpus Christi Police Department.
115.234 (d) The facility does not has an MOU with the Corpus Christi Police department.
however, will forward all criminal investigations to CCPD.

Corrective Action: The auditor recommends no corrective action.

Standard 115.235: Specialized training: Medical and mental health care

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

115.235 (a)

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? ☒ Yes ☐ No

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

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

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

115.235 (b)

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

115.235 (c)

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere?
  ☒ Yes ☐ No

115.235 (d)

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

- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? [N/A for circumstances in which a particular status (employee or contractor/volunteer) does not apply.]
  ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:

Primary:

A. Policy 14-2 CC Sexual Abuse Prevention and Response

Secondary:

1. Photos of PREA Training Video (Specialty Staff)
2. Screenshots of objectives in DVD
3. Course Description (facilitators guide)
4. LVN Training Record (new employee in training)

Findings:
The facility does not have contracted medical and mental health services, the services are provided by outside licensed medical and mental health staff community services, TDCJ referrals or the Purple Door. The SAFE/SANE will be conducted through the Purple Door as described in the MOU. The facility will seek information of any and all sexual assault allegations by reaching out to the SANE/SANE individuals and or the Purple Door with the permission of the resident.

Corrective Action: The auditor recommends no corrective action.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.241: Screening for risk of victimization and abusiveness

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

115.241 (a)

- Are all residents assessed during an intake screening for their risk of being sexually abused by other residents or sexually abusive toward other residents? ☒ Yes ☐ No

- Are all residents assessed upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents? ☒ Yes ☐ No

115.241 (b)

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

115.241 (c)

- Are all PREA screening assessments conducted using an objective screening instrument?
  ☒ Yes ☐ No

115.241 (d)

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has a mental, physical, or developmental disability? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The age of the resident? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The physical build of the resident? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously been incarcerated?
  ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident's criminal history is exclusively nonviolent?
  ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has prior convictions for sex offenses against an adult or child? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming (the facility affirmatively asks the resident about his/her sexual orientation and gender identity AND makes a subjective determination based on the screener's perception whether the resident is gender non-conforming or otherwise may be perceived to be LGBTI)? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously experienced sexual victimization? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The residents own perception of vulnerability? ☒ Yes ☐ No

115.241 (e)

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior acts of sexual abuse? ☒ Yes ☐ No

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior convictions for violent offenses? ☒ Yes ☐ No

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: history of prior institutional violence or sexual abuse? ☒ Yes ☐ No

115.241 (f)

- Within a set time period not more than 30 days from the resident's arrival at the facility, does the facility reassess the resident's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening? ☒ Yes ☐ No

115.241 (g)

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

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

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

- Does the facility reassess a resident's risk level when warranted due to a: Receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness? ☒ Yes ☐ No

115.241 (h)

- Is it the case that residents are not ever disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section? ☒ Yes ☐ No

115.241 (i)

- Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:
Documentation Reviewed:

Primary:

A. Policy 14-2 CC Sexual Abuse Prevention and Response

Secondary:

1. 14-02B CC Sexual Abuse Screening Tool-Initial
2. 14-02B CC Sexual Abuse Screening Tool-30 Day Reassessment (f)
3. Memo to Staff stating residents will not be disciplined for refusing to answer questions (h)

Interviews:

1. Staff responsible for Risk Screening
2. Random residents
3. PREA Coordinator

Site Observations:

The facility provided the auditor with a list of documents through a secured website that included: Audit notices, PREA files, residents who reported sexual abuse, PREA log, residents housing roster, sexual victimization roster, policies, PREA audit questionnaire, employee list, and supporting documentation.

Name of Record	Number Reviewed
Employee Files/Training/Background (40)	20
Volunteer /Contractor	2V/1C
Resident Files (130)	20
Specialized training	2
Investigative File	3
Total Files	47

Employee Files: The auditor reviewed a total of 20 employee files with training records and background checks that corresponded with employees interviewed during the onsite phase of the audit. The auditor selected the 20

employee files from the same list of the 40 reviewed files with a random selection in no specific order. The auditor attempted to review a few monitors, department heads and volunteers.
The facility provided the auditor with information regarding one contractor during the 12 months preceding the audit. The auditor reviewed the contractor information and PREA training. The contractor was on longer assigned to the facility during the onsite PREA audit, therefore, the auditor did not conduct any contractor interviews.

Resident Files: The auditor reviewed a total of 20 files which corresponded with the resident interview list of 20 residents during the onsite phase of audit meeting all categories.

Findings:

115.241 (a) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 12 section H. Intake staff interviewed interview the residents upon arrival and reassessed within 30-days.

18 of 20 random residents remember being interviewed and the other two offenders said they didn't remember. The assessments/interviews were verified by the residents signature on the form.

115.241 (b) The number of residents entering the facility (either through intake or transfer) within the past 12 months (whose length of stay in the facility was for 72 hours or more) who were screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their entry into the facility: 796. A total of 20 resident files were reviewed for the screening process and the initial risk screening. The intake staff was interviewed and described the PREA interview process and 30-day reassessment.

115.241 (c) The facility utilizes a sexual abuse screening tool for the initial screening, 30-day reassessment and new information.

115.241 (d) The facility utilizes a sexual abuse screening tool for the initial screening, and 30-day reassessment with the required criteria.

115.241 (e) A review of the initial risk screening for 20 residents determined that the question is on the form.

115.241 (f) The auditor reviewed a total of 20 resident for the initial and 30-day reassessment.

115.241 (g) Policy 14-2 Sexual Abuse Prevention and Response pg. 12 section H. The auditor reviewed a total of 26 resident for the initial and 30-day reassessment. There was a total of three files that did not have the initial and seven that required the 30-day reassessment.

115.241 (h) There were no residents disciplined for refusing to answer or for not disclosing complete information.

115.241 (i) Policy 14-2 Sexual Abuse Prevention and Response 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.

Corrective Action: The auditor recommends no corrective action.

Standard 115.242: Use of screening information

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

115.242 (a)

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

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

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

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

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

115.242 (b)

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

115.242 (c)

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the residents 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 ☐ No

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

115.242 (d)

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

115.242 (e)

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

115.242 (f)

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

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:

Primary:

A. Policy 14-2 CC Sexual Abuse Prevention and Response

Secondary:

1. Sexual Abuse Screening Tool Directions (tracking predators, potential predators, victims and potential victims)
2. 14-02B CC Initial Sexual Abuse Screening
3. PREA Bunk Assignments
4. Memo: Procedures for Transgender and Intersex Resident Showering

Interviews:

1. PREA Coordinator
2. Staff responsible for Risk Screening
3. Transgender/Intersex residents Interviews (the facility did not have any residents listed for interviews in this specific area Transgender/Intersex residents)

Site Review Observations:

The site review consisted of random interviews with male residents, observing the practice, to include privacy and cross-gender viewing for the shower and toilet areas. The PREA Coordinator interview determined that transgender and intersex will be provided with the opportunity to shower separately and all policies will be followed on an individual basis. There were no assigned Transgender or Intersex residents for the past 12 months.

Findings:

115.242 (a) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 12 section H. The interview conducted with the intake monitor and PCM determined that the information from the initial risk screening is used to protect the residents from sexual abuse by assessing their housing assignment, work, and outside activity. The assessment is to ensure their overall safety. The auditor reviewed the assessment form which reflected every provision of the standard.

115.242 (b) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 12 section e. Staff who conduct the screenings for risk of victimization and abusiveness were interviewed and stated that the information was assessed for each individual coming in by assessing all the information on the screens, verifying the questions and answers to their individual safety. If the resident requires monitoring, the codes of Victim, Potential Victim, Potential Predator and Predator and suicide alert will be entered immediately.

115.242 (c) Policy 14-2 Sexual Abuse Prevention and Response pg. 14 section J. The PC/Screening staff interview determined that every individual is assessed upon arrival and is given the opportunity to identify as LGBTI. Residents are also given the opportunity to address their views during the committee for consideration of placement or programs. The facility did not have any assigned residents who identified as Transgender or Intersex for interviews.

115.242 (d) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 14 section J. The PCM/Screening staff interview determined that every individual is assessed upon arrival and is given the opportunity to identify as LGBTI. Residents are also given the opportunity to address their views during the committee for consideration of placement or programs. The facility did not have any assigned residents who identified as Transgender or Intersex for interviews.

115.242 (e) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 14 section J. The PCM/Screening staff interview determined that every individual is assessed upon arrival and is given the opportunity to identify as LGBTI. Residents are also given the opportunity to address their views during the committee for consideration of placement or programs. The facility did not have any assigned residents who identified as Transgender or Intersex for interviews.

115.242 (f) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 15 section 7. The interview with the PCM/Screening staff and policy review determined that Transgender and Intersex offenders are provided with the opportunity to shower separately from other residents according to policy.

Corrective Action: The auditor recommends no corrective action.

REPORTING

Standard 115.251: Resident reporting

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

115.251 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? ☒ Yes ☐ No

115.251 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No
- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No
- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No

115.251 (c)

- Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties? ☒ Yes ☐ No
- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.251 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:

Primary:

A. Policy 14-2 CC Sexual Abuse Prevention and Response

Secondary:

1. PREA Poster (a,b)
2. CoreCivic Brochures (English and Spanish) (a,b)
3. CoreCivic Website (a)
4. Resident Handbook & Signed Resident Acknowledgement of Handbook
5. CoreCivic Staff PREA Poster (d)

Interviews:

1. Random sample of staff
2. Random sample of residents
3. PREA Coordinator

Site Review Observations:

The auditor observed the PREA information and reporting procedures posted throughout the facility in both English and Spanish during the site review.

Findings:

115.251 (a) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 15 section L. During the facility site review, random residents were asked about the reporting process for sexual abuse and sexual harassment; both staff and residents were able to describe how the reports would be made. 20 of 20 staff members interviewed stated that residents can report using the PREA hotline, tell a family member, the PREA notices posted throughout the facility and the PREA hotline.

115.251 (b) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 16 section 2. There are no residents detained solely for immigration purposes. 20 of 20 staff members interviewed stated that residents can report using the PREA hotline, tell a family member, the PREA notices posted throughout the facility and the PREA hotline.

115.251 (c) The facility has a Memorandum of Understanding the Purple Door in Corpus Christi, TX with a direct free phone number for residents to call at any time. 10 random resident interviews said during the interview that the phones in the dayroom had a PREA hotline number for use. The auditor contacted the representative at the Purple door for a review of sexual abuse reports. There have been no reports made in the past 12 months.

115.251 (d) CoreCivic provides an Ethics line available for all staff 24 hours a day, seven days a week at 1-866-757-4448 on the website www.corecivic.ethicspoint.com. 10 random staff interviews described how to use the Ethics line.

Corrective Action: The auditor recommends no corrective action.

Standard 115.252: Exhaustion of administrative remedies

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

115.252 (a)

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

115.252 (b)

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

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

115.252 (c)

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

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

115.252 (d)

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

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

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

115.252 (e)

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

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

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

115.252 (f)

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

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

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

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

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

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

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

115.252 (g)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:

Primary:

A. Policy 14-2 CC Sexual Abuse Prevention and Response

Secondary:

1. 14-100 CC Sexual Abuse Prevention and Response
2. Resident Grievance Form

Interviews:

1. Residents who reported sexual abuse (there were no residents who reported sexual abuse assigned to the facility during the onsite portion of the audit for interviews)

Findings:

115.252 (a) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 16 section b. Unless otherwise mandated by the contract, alleged PREA incidents will not be processed through the facility grievance process and will immediately be referred to the facility investigator or Facility Director for investigation. The PC interviewed determined that residents are allowed to submit a sexual abuse grievance, however, upon receiving the grievance of a sexual nature it is immediately categorized a priority and forwarded to the facility investigator for immediate action.

115.252 (b) The interview it the PC and Investigator determined that there are no timeframes for the submission of a grievance. The grievance process in the resident handbook.

115.252 (c) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 17. The resident handbook provides the information under Resident Grievances.

115.252 (d) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 17. Unless otherwise mandated by the contract, alleged PREA incidents will not be processed through the facility grievance process and will immediately be referred to the facility investigator or Facility Director for investigation.

The PC interviewed determined that residents are allowed to submit a sexual abuse grievance, however, upon receiving the grievance of a sexual nature it is immediately categorized a priority and forwarded to the facility investigator for immediate action.

115.252 (e) The facility has a Memorandum of Understanding the Purple Door in Corpus Christi, TX with a direct free phone number for residents to call at any time. 10 random resident interviews said during the interview that the phones in the dayroom had a PREA hotline number for use. The auditor contacted the representative at the Purple Door for a review of sexual abuse reports. The residents can request assistance from other residents or staff for the assistance of a report.

115.252 (f) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 17. Unless otherwise mandated by the contract, alleged PREA incidents will not be processed through the facility grievance process and will immediately be referred to the facility investigator or Facility Director for investigation. The PC interviewed determined that residents are allowed to submit a sexual abuse grievance, however, upon receiving the grievance of a sexual nature it is immediately categorized a priority and forwarded to the facility investigator for immediate action. All sexual abuse grievances are processed as emergency grievances.

115.252 (g) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 17. 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: 0.

Corrective Action: The auditor recommends no corrective action.

Standard 115.253: Resident access to outside confidential support services

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

115.253 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? ☒ Yes ☐ No

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

115.253 (b)

- Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws? ☒ Yes ☐ No

115.253 (c)

- Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse? ☒ Yes ☐ No

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:

Primary:

A. Policy 14-2 CC Sexual Abuse Prevention and Response

Secondary:

1. PREA Resident Reporting Poster and National Sexual Assault Hotline Information
2. Memorandum of Understanding-Coastal Bend Wellness Foundation
3. Memorandum of Understanding-The Purple Door

Interviews:

1. Random sample of residents
2. Residents who reported sexual abuse

Site Review Observations:

Findings:

115.253 (a) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 10 section F. The facility has a Memorandum of Understanding with the Purple Door in Corpus Christ, TX. This information is in the Resident handbook; You can also contact the Purple Door, in writing or by telephone as follows: 24-hour Crisis hotline: 361-881-8888 or 800 582- HURT (4878). Address: P.O. Box 3368 Corpus Christi, TX 78463. Sexual Assault Services include crisis intervention and advocacy, available to adult survivors of stranger and non-stranger sexual assault at no charge. 24 hours per day, 7 days a week, 365 days per year.

115.253 (b) The auditor tested the line to the Purple Door hotline and CCTC does not monitor the phones or view incoming or outgoing mail. Random interviews with the resident population determined that they understood the how to contact the PREA hotline and the Purple Door.

115.253 (c) The facility has a Memorandum of Understanding with the Purple Door in Corpus Christi, TX.

Corrective Action: The auditor recommends no corrective action.

Standard 115.254: Third-party reporting

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

115.254 (a)

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:

Primary:

A. Policy 14-2 CC Sexual Abuse Prevention and Response

Secondary:

1. CoreCivic Webpage
2. CoreCivic Brochures (English and Spanish)
3. Resident Handbook and Signed Resident Acknowledgement of Handbook

Site Review Observations:

During the site review, the auditor observed the Third-Party notices in visitation, staff areas and other locations throughout the facility. The Third-Party information is also provided on the agency website.

Findings:

115.254 (a) Policy 14-2 Sexual Abuse Prevention and Response pg. 17 section 4.
Write to the facility at the following address:
Third Party Reporting Method(s):
Texas Department of Criminal Justice PREA Ombudsman Office
P.O. Box 99
Huntsville, TX 77342-0099

Phone (936) 437-2133 or 1- 800-535-0283
E-mail: prea.ombudsman@tdcj.texas.gov
Corpus Christi Transitional Center
Attention: Facility Director
1515 North Tancahua
Corpus Christi, TX 78401
361-883-1004
CALL THE CORECIVIC 24-HOUR ETHICS LINE:1-866-757-4448 or VISIT www.CoreCivic.ethicspoint.com

Corrective Action: The auditor recommends no corrective action.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.261: Staff and agency reporting duties

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

115.261 (a)

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

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

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

115.261 (b)

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

115.261 (c)

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

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

115.261 (d)

- If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, does the agency report the allegation to the designated State or local services agency under applicable mandatory reporting laws? ☒ Yes ☐ No

115.261 (e)

- Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:

Primary:

A. Policy 14-2 Sexual Abuse Prevention and Response

Secondary:

1. CoreCivic First Responder Card
2. 14-02C CC Sexual Abuse Incident Check Sheet
3. PREA Investigation Report (Facility Investigators)

Interviews:

1. Random sample of staff
2. Director or Designee
3. PREA Coordinator
4. Medical and Mental Health Staff

Findings:

115.261 (a) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 16 section 2. 10 random staff interviews conducted on the facility determined that staff understands their duties and responsibilities of reporting.

115.261 (b) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 17 section e. 10 random staff interviews conducted on the facility determined that staff understands their duties and responsibilities of reporting and confidentiality.

115.261 (c) The facility does not have medical staff contracted or assigned to the facility for interviews.

115.261 (d) Texas has Criminal Laws Prohibiting Sexual Abuse of Individuals in Custody https://nicic.gov/fifty-state-survey-criminal-laws-prohibiting-sexual-abuse-individuals-custody

115.261 (e) There have been no reports of retaliation against staff or residents who have reported information regarding sexual abuse or sexual harassment upon interviewing Human Resources and the Facility Director.

Corrective Action: The auditor recommends no corrective action.

Standard 115.262: Agency protection duties

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

115.262 (a)

- When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:

Primary:

A. Policy 14-2 CC Sexual Abuse Prevention and Response

Secondary:

1. First Responder Card
2. 14-02C CC Sexual Abuse Incident Check Sheet

Interviews:

1. Facility Director
2. Random sample of staff

Findings:

115.262 (a) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 12 section H. In the past 12 months, the number of times the agency or facility determined that a resident was subject to a substantial risk of imminent sexual abuse: 0. The Facility Directors interview determined that upon receiving any information of the substantial risk, all measures will be taken to safeguard the offender. 20 of 20 random staff explained their responsibilities for any resident that is subject to a substantial risk of imminent sexual abuse.

Corrective Action: The auditor recommends no corrective action.

Standard 115.263: Reporting to other confinement facilities

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

115.263 (a)

- Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred? ☒ Yes ☐ No

115.263 (b)

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

115.263 (c)

- Does the agency document that it has provided such notification? ☒ Yes ☐ No

115.263 (d)

- Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:

Primary:

A. Policy 14-2 CC Sexual Abuse Prevention and Response

Secondary:

1. PREA Reporting Information

Interviews:

1. Facility Director

Findings:

115.263 (a) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 20 section a. During the past 12 months, the number of allegations the facility received that a resident was abused while confined at another facility: 0. The auditor reviewed this investigation.

115.263 (b) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 20 section a.

115.263 (c) The facility documents this information by email and on the report.

115.263 (d) In the past 12 months, the number of allegations of sexual abuse the facility received from other facilities: 0. The Facility Director interview determined that the process was in place and all protocols will be followed.

Corrective Action: The auditor recommends no corrective action.

Standard 115.264: Staff first responder duties

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

115.264 (a)

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

115.264 (b)

- If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:

Primary:

A. Policy 14-2 CC Sexual Abuse Prevention and Response

Secondary:

1. CoreCivic First Responder Card
2. PREA Overview Facilitator's Guide

Interviews:

1. First Responders
2. Random sample of staff

Findings:

115.264 (a) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 18 section C. 20 of 20 random staff interviews determined that staff understands the importance of first responder duties. (1) Separate the alleged victim and abuser; (2) Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence; (3) If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and/or (4) If the abuse occurred within a time period that still allows for the collection of physical evidence, 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. In the past 12 months, the number of allegations that an resident was sexually abused: 1. Of these allegations, the number of times the first security staff member to respond to the report separated the alleged victim and abuser: 0. In the past 12 months, the number of allegations where staff were notified within a time period that still allowed for the collection of physical evidence: 1.

115.264 (b) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 18. Of the allegations that an resident was sexually abused made in the past 12 months, the number of times a non-security staff member was the first responder: 3. Of those allegations responded to first by a non-security staff member, the number of times that staff member : (1) Requested that the alleged victim not take any actions that could destroy physical evidence: 0. (2) Notified security staff: 0. 20 of 20 random staff interviews determined that staff understands the importance of first responder duties.

Corrective Action: The auditor recommends no corrective action.

Standard 115.265: Coordinated response

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

115.265 (a)

- Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:
Documentation Reviewed:

Primary:

A. Policy 14-2 CC Sexual Abuse Prevention and Response

Secondary:

1. CoreCivic First Responder Card
2. Facility Sexual Abuse Response team (SART) minutes
3. PREA Investigation Report
4. 14-02F CC Sexual Abuse or Assault Incident

Interviews:

1. Facility Director
2. Investigative staff

Findings:

115.265 (a) Policy 14-2 CC Sexual Abuse and Response pg. 17 section M. A facility review of policy and the Facility Directors interview determined the facility has a plan to coordinate amongst first staff responders, investigators and facility administration. The facility does not have contracted medical or mental health employees, the services are community based by a trained medical professional. This was determined by the interviews with the Facility Director & Investigator.

Corrective Action: The auditor recommends no corrective action.

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

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

115.266 (a)

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

115.266 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:

Primary:

A. Policy 14-2 CC Sexual Abuse and Response

Secondary:

No collection bargaining agreements at Corpus Christi Transitional Center

Interviews:

1. Agency head

Findings:

115.266 (a) Policy 14-2 Sexual Abuse Prevention and Response pg. 27 section 2. No collection bargaining agreements at Corpus Christi Transitional Center. The agency head interview determined that CoreCivic as an agency has entered into and/or renewed collective bargaining agreements since 8/20/12. The agreements permit CoreCivic to removed alleged staff sexual abusers from contact with an inmate pending an investigation or disciplinary action.

115.266 (b) Policy 14-2 Sexual Abuse Prevention and Response pg. 27 section 2. No collection bargaining agreements at Corpus Christi Transitional Center.

Corrective Action: The auditor recommends no corrective action.

Standard 115.267: Agency protection against retaliation

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

115.267 (a)

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

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

115.267 (b)

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

115.267 (c)

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

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

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

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

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

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

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

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

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

115.267 (d)

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

115.267 (e)

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

115.267 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:

Primary:

A. Policy 14-2 CC Sexual Abuse Prevention and Response

Secondary:

1. 14-02D CC PREA Retaliation Monitoring Report

Interviews:

1. Agency head
2. Facility Director
3. Designated staff member charged with monitoring retaliation
4. Residents who reported sexual abuse

Findings:

115.267 (a) Policy 14-2 Sexual Abuse Prevention and Response pg. 10 section F. The facility has assigned a Grievance Coordinator/PREA Coordinator for this position.

115.267 (b) Policy 14-2 Sexual Abuse Prevention and Response pg. 11 section 3. The Facility Director, staff designated with monitoring retaliation and explained the reporting process and protection from retaliation.

115.267 (c) The number of times an incident of retaliation occurred in the past 12 months: 0. The Facility Director, staff designated with monitoring retaliation and the PCM explained the reporting process and protection from retaliation.

115.267 (d) The length of time that the agency/facility monitors the conduct or treatment: 30, 60 90 days with no limitations and a reassessment of the investigation if required according to the Facility Director and staff assigned to monitor retaliation.

115.267 (e) The Facility Director interview determined that staff or resident witness involved in the reporting process of a sexual abuse would be monitored for retaliation.

115.267 (f) Unfounded cases will not be monitored.

Corrective Action: The auditor recommends no corrective action.

INVESTIGATIONS

Standard 115.271: Criminal and administrative agency investigations

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

115.271 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).]
  ☒ Yes ☐ No ☐ NA

115.271 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations as required by 115.234? ☒ Yes ☐ No

115.271 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? ☒ Yes ☐ No

- Do investigators interview alleged victims, suspected perpetrators, and witnesses?
  ☒ Yes ☐ No

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

115.271 (d)

- When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution? ☒ Yes ☐ No

115.271 (e)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff?
  ☒ Yes ☐ No

- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? ☒ Yes ☐ No

115.271 (f)

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

- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? ☒ Yes ☐ No

115.271 (g)

- Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible? ☒ Yes ☐ No

115.271 (h)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution? ☒ Yes ☐ No

115.271 (i)

- Does the agency retain all written reports referenced in 115.271(f) and (g) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years? ☒ Yes ☐ No

115.271 (j)

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation? ☒ Yes ☐ No

115.271 (k)

- Auditor is not required to audit this provision.

115.271 (l)

- When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? [N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:
Documentation Reviewed:

Primary:

A. Policy 14-2 CC Sexual Abuse Prevention and Response

Secondary:

1. PREA Investigation Report
2. 1-1B CC CoreCivic Record Retention Schedule
3. PREA Investigator Training Certificates and PREA Investigator Curriculum
4. Memorandum of Understanding-Corpus Christi Department (pending meeting & signature)

Interviews:

1. Investigative staff
2. Residents who reported sexual abuse
3. Director
4. PREA Coordinator

Findings:

115.271 (a) Policy 14-2 Sexual Abuse Prevention and Response pg. 7 section b. The auditor reviewed a total of two sexual abuse allegations investigated administratively by a trained investigator. The investigator stated that the facility is working to obtain an MOU with the Corpus Christi Police Department for criminal cases.

115.271 (b) The auditor reviewed documentation for investigators who took the specialized training placed in their file.

115.271 (c) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 7 section d. The auditor reviewed a total of sexual abuse allegations investigated administratively by a trained investigator. The retention of files will be adhered to the facility policy.

115.271 (d) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 7 section d. The auditor reviewed a total of two sexual abuse allegations investigated administratively by a trained investigator. The investigator stated that the facility is working to obtain an MOU with the Corpus Christi Police Department for criminal cases.

115.271 (e) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 11. The investigator stated that the credibility of the victim, suspect or witness will be assessed on an individual basis.

115.271 (f) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 16. The investigative interview determined that they will consider staff actions, to include all facts and findings and follow all protocols of sexual abuse and sexual harassment.

115.271 (g) The investigator interview determined that all investigations are documented. The auditor reviewed the two documented investigations and one that was pending.

115.271 (h) The investigator and Facility Director interview determined that nay substantiated allegation of conduct that appear to be criminal will be referred to the Corpus Christ Police Department for further

investigation. The number of substantiated allegations of conduct that appear to be criminal that were referred for prosecution since August 20, 2012, or since the last PREA audit, whichever is later: 0.

115.271 (i) The investigations reviewed are maintained as long as the alleged abuser is incarcerated or employed by the agency, plus five years according to the retention schedule.

115.271 (j) The interview with the Facility Director and Investigative staff determined that the investigation will continue to monitor whether the victim/abuser have left the agency for completion and the outcome of the investigation.

115.271 (k) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 17.

115.271 (l) The Facility Director and Investigator were interviewed and stated that they would comply with all efforts and remain engaged during an investigation of an outside agency.

Corrective Action: The auditor recommends no corrective action.

Standard 115.272: Evidentiary standard for administrative investigations

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

115.272 (a)

- Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:

Primary:

A. Policy 14-2 CC Sexual Abuse Prevention and Response

Secondary:

1. Investigation Report
2. Preponderance of Evidence

Interviews:

1. Investigative staff

Site Review Observations:

Findings:

115.272 (a) Policy 14-2 Sexual Abuse Prevention and Response pg. 26 section 5. The interview with the investigator determined that the facility will not impose standards higher than preponderance of the evidence when making decisions.

Corrective Action: The auditor recommends no corrective action.

Standard 115.273: Reporting to residents

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

115.273 (a)

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

115.273 (b)

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

115.273 (c)

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

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.273 (d)

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.273 (e)

- Does the agency document all such notifications or attempted notifications? ☒ Yes ☐ No

115.273 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:

Primary:

A. Policy 14-2 CC Sexual Abuse Prevention and Response

Secondary:

1. PREA Investigation Report
2. 14-02C CC Resident PREA Allegation Status Notification
3. PREA Investigator's Statement

Interviews:

1. Facility Director
2. Investigative staff
3. Residents who reported sexual abuse

Site Review:

Investigation Files: The auditor reviewed three sexual abuse allegations for the past twelve months. One of the investigations was Staff-on-Resident and one investigation was Residents. The facility administrator provided the investigations to the auditor on the first day of the audit for review. The auditor reviewed two investigations provided by the facility to include an interview with the facility investigator. The auditor reviewed on case that was currently open and pending. The auditor reviewed the administrative investigation records, including retaliation monitoring for alleged victims, for incidents of sexual abuse and sexual harassment that were reported in the past 12 months immediately preceding the audit.

The facility had two investigators who are responsible for conducting all administrative investigations and all criminal investigations are forwarded to the local police department for further investigation. The facility reviewed the Grievances for the past 12 months and the facility had no grievances related to PREA. There were no records of criminal investigations pending during the audit. The investigation dispositions are shown below:

Description	Status	Criminal Case/Disposition	Criminal/Administrative
4. Resident-on-Resident	Unfounded	No case opened	Administrative
5. Staff-on-Resident	Unfounded	No case opened	Administrative
6. Staff-on-Resident	Pending/Open Case	Referred to CCPD	Administrative

Findings:

115.273 (a) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 26 section Q. The number of criminal and/or administrative investigations of alleged resident sexual abuse that were completed by the agency/facility in the past 12 months: 3. Of the alleged sexual abuse investigations that were completed in the past 12 months, the number of residents who were notified, verbally or in writing, of the results of the investigation: 2. The auditor reviewed a total of three investigations within required timeframe. The auditor reviewed a current pending investigation. The Facility Director and investigator were interviewed and knowledgeable of the process. There were on residents onsite who reported sexual abuse for interviews.

115.273 (b) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 25 & 27. The number of investigations of alleged resident sexual abuse in the facility that were completed by an outside agency in the past 12 months: 0. The auditor reviewed a total of two investigations.

115.273 (c) There were no substantiated cases for the past 12 months.

115.273 (d) There have been no substantiated cases for resident-on-resident allegations for the past 12 months requiring a notification.

115.273 (e) There have been no substantiated cases for resident-on-resident allegations for the past 12 months requiring a notification.

115.273 (f) The facility's obligation to report under this standard shall terminate if the resident is released from custody.

Corrective Action: The auditor recommends no corrective action.

DISCIPLINE

Standard 115.276: Disciplinary sanctions for staff

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

115.276 (a)

- Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? ☒ Yes ☐ No

115.276 (b)

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

115.276 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories? ☒ Yes ☐ No

115.276 (d)

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies unless the activity was clearly not criminal? ☒ Yes ☐ No

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:
Primary:
A. Policy 14-2 CC Sexual Abuse Prevention and Response

Secondary:
Administrative Leave Letter for staff pending investigation

Findings:

115.276 (a) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 28 section 2. the past 12 months, the number of staff from the facility who have violated agency sexual abuse or sexual harassment policies: 0.

115.276 (b) There have been no disciplinary or terminations for staff regarding sexual abuse or sexual harassment. The two staff-on-residents were unfounded and one pending the outcome of the investigation. There was a review of the Administrative Leave Letter for staffing pending the investigation.

115.276 (c) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 28 section 2. the past 12 months, the number of staff from the facility who have violated agency sexual abuse or sexual harassment policies: 0. There have been no disciplinary or terminations for staff regarding sexual abuse or sexual harassment. The two staff-on-residents were unfounded and one pending the outcome of the investigation. There was a review of the Administrative Leave Letter for staffing pending the investigation.

115.276 (d) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 28 section 2. the past 12 months, the number of staff from the facility who have violated agency sexual abuse or sexual harassment policies: 0. There have been no disciplinary or terminations for staff regarding sexual abuse or sexual harassment. The two staff-on-

residents were unfounded and one pending the outcome of the investigation. There was a review of the Administrative Leave Letter for staffing pending the investigation.

Corrective Action: The auditor recommends no corrective action.

Standard 115.277: Corrective action for contractors and volunteers

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

115.277 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies unless the activity was clearly not criminal? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? ☒ Yes ☐ No

115.277 (b)

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:

Primary:

A. Policy 14-2 CC Sexual Abuse Prevention and Response

Interviews:

1. Facility Director

Findings:

115.277 (a) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 29 section 3. The interview with the Facility Director determined there have been no allegations or reports of sexual abuse or sexual harassment by volunteers or contractors at the facility for the past 12 months.

115.277 (b) The interview with the Facility Director determined that the facility takes all measures and prohibits contact with residents in the event of a violation of sexual abuse by a volunteer or contractor. The volunteer or contractor would not be allowed on the facility until completion of investigation for the protection of the offender.

Corrective Action: The auditor recommends no corrective action.

Standard 115.278: Interventions and disciplinary sanctions for residents

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

115.278 (a)

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, are residents subject to disciplinary sanctions pursuant to a formal disciplinary process? ☒ Yes ☐ No

115.278 (b)

- Are sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories? ☒ Yes ☐ No

115.278 (c)

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior? ☒ Yes ☐ No

115.278 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to require the offending resident to participate in such interventions as a condition of access to programming and other benefits? ☒ Yes ☐ No

115.278 (e)

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

115.278 (f)

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

115.278 (g)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:

Primary:

A. Policy 14-2 CC Sexual Abuse Prevention and Response

Secondary:

Resident Handbook & Signed Resident Acknowledgement of Handbook

Zero Tolerance Acknowledgement for Residents with a signature

Mental Health/Suicide Risk Assessment (used at all TTMs to determine sanctions)

The Purple Door Brochure

Interviews:

1. Facility Director
2. Director
3. Medical/Mental health staff

Findings:

115.278 (a) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 27 section A. In the past 12 months, the number of administrative findings of resident-on-resident sexual abuse that have occurred at the facility: 1. In the past 12 months, the number of criminal findings of guilt for resident-on-resident sexual abuse that have occurred at the facility: 0.

115.278 (b) The Facility Directors interview determined that there were no incidents of disciplinary sanctions imposed on residents during the past 12 months for substantiated resident-on-resident sexual abuse or criminal findings of guilt for resident-on-resident sexual abuse, or for resident-on-staff sexual contact abuse.

115.278 (c) The Facility Directors interview determined that the residents mental disabilities or mental illness contributed to his or her behavior when making decisions on the types of sanctions to be imposed.

115.278 (d) The facility does not have medical or mental health staff assigned to the facility therefore no medical staff interviews were conducted. All medical services are provided by a community medical professional.

115.278 (e) The Facility Director interview determined that there were no incidents of disciplinary sanctions imposed on residents during the past 12 months for substantiated resident-on-resident sexual abuse or criminal findings of guilt for resident-on-resident sexual abuse, or for resident-on-staff sexual contact abuse.

115.278 (f) The Facility Directors interview determined that the facility prohibits disciplinary action for a report made in good faith.

115.278 (g) 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.

Corrective Action: The auditor recommends no corrective action.

MEDICAL AND MENTAL CARE

Standard 115.282: Access to emergency medical and mental health services

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

115.282 (a)

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment?
  ☒ Yes ☐ No

115.282 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do security staff first responders take preliminary steps to protect the victim pursuant to § 115.262? ☒ Yes ☐ No

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

115.282 (c)

- Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate? ☒ Yes ☐ No

115.282 (d)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:

Primary:

A. PCN 12-2(01)CC
B. Policy 14-2 CC Sexual Abuse Prevention and Response

Secondary:

1. Emergency-Spohn Hospitals in Corpus Christi
2. MOU-Coastal Bend Wellness Foundation
3. The Purple Door Sexual Assault Services
4. Victims of Assault Services
5. 14-02 CC Sexual Abuse Incident Check Sheet

Interviews:

1. Medical/Mental health staff
2. Residents who reported sexual abuse
3. Security staff and non-security staff first responders

Findings:

115.282 (a) The facility does not have medical or mental health staff assigned to the facility. The MOU with the Purple Door describes in detail the services provided and Local Hospitals are available for community-based services by medical professionals. The Purple Door provides services 24/7 free of charge.

115.282 (b) The facility does not have medical or mental health staff assigned to the facility. The MOU with the Purple Door describes in detail the services provided and Local Hospitals are available for community-based services by medical professionals. The Purple Door provides services 24/7 free of charge.

115.282 (c) The interview with the Facility Director and Purple Door representative and a review of documentation determined that resident victims of sexual abuse are provided with the standard community-based care by medical trained professionals.

115.282 (d) The interview with the Facility Director and review of the MOU with the purple door determined that victims of sexual abuse are provided the services without financial cost.

Corrective Action: The auditor recommends no corrective action.

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

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

115.283 (a)

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

115.283 (b)

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

115.283 (c)

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

115.283 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.) ☐ Yes ☐ No ☒ NA

115.283 (e)

- If pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.) ☐ Yes ☐ No ☒ NA

115.283 (f)

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

115.283 (g)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

115.283 (h)

- Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:

Primary:

A. Policy 14-2 CC Sexual Abuse Prevention and Response

Secondary:

1. Memorandum of Understanding-Coastal Bend Wellness Foundation
2. The Purple Door Sexual Assault Services & other local services

Interviews:

1. Medical and Mental health staff
2. Residents who reported a sexual abuse

Findings:

115.283 (a) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 2. The auditor reviewed a total of 20 resident files. The MOU with the Purple Door provides appropriate treatment for all residents who have been a victim of sexual abuse in a confinement setting. The Purple door representative was interviewed, and the services are provided free of charge. There were no residents onsite during the audit process for interviews. The auditor reviewed the Memorandum of Understanding between CoreCivic of Tennessee, LLC/Corpus Christi Transitional Center (CCTC) and the Purple Door. The document establishes guidelines for the provision of victim services to residents in custody by and between Corpus Christi Transitional Center and Women's Shelter of South Texas D/B/A/ The Purple Door. The Purple door agrees to arrange for forensic examinations for resident victims of sexual abuse, such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs), follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. Provide a victim advocate, if requested by the victim; contact facility personnel and provide the identity of the victim advocate responding to the forensic exam. Provide 24-hour sexual abuse/assault crisis line number and the Purple Door mailing addresses that may be posted throughout the facility and in written resources given to residents. On 4/1/19, the 24-hour Crisis Hotline was tested by the auditor and was in good working condition, the representative stated that no calls had been received from the facility. On 4/1/19, the auditor contacted the SANE/SAFE nurse on-call, the process for a sexual assault was explained, and no other information was disclosed regarding the facility on that specific night. The residents interviewed by the auditor understood how to contact the rape crisis center directly at any time if needed.

115.283 (b) The Facility Director interview determined that treatment is offered to all residents who have been victims of sexual abuse. The facility has a Memorandum of Understanding with the Purple Door in Corpus Christ, TX. This information is in the Resident handbook; You can also contact the Purple Door, in writing or by telephone as follows: 24-hour Crisis hotline: 361-881-8888 or 800 582- HURT (4878). Address: P.O. Box 3368 Corpus Christi, TX 78463. Sexual Assault Services include crisis intervention and advocacy, available to adult survivors of stranger and non-stranger sexual assault at no charge. 24 hours per day, 7 days a week, 365 days per year.

115.283 (c) The Facility Director interview determined that treatment is offered to all residents who have been victims of sexual abuse consistent with the community level of care.

115.283 (d) N/A This is an all-male facility.

115.283 (e) N/A This is an all-male facility.

115.283 (f) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 2. There were no instances which required for testing of sexually transmitted infections.

115.283 (g) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 25. The Purple door MOU determined that treatment services are provided to the victim without any financial cost.

115.283 (h) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 25 section C. The Purple Door offers the services to all residents free of charge. Both victims and abusers receive the same level of care.

Corrective Action: The auditor recommends no corrective action.

DATA COLLECTION AND REVIEW

Standard 115.286: Sexual abuse incident reviews

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

115.286 (a)

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

115.286 (b)

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

115.286 (c)

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

115.286 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No

- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No

- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No

- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No

- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No

- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.286(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.286 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:

Primary:

A. Policy 14-2 CC Sexual Abuse Prevention and Response

Secondary:

1. 14-02F CC Sexual Assault or Abuse Incident Review Form
2. PREA 5-1 Incident Reporting Definitions
3. 5-1E PREA Reporting

Interviews:

1. Facility Director

2. PREA Coordinator
3. Incident Review Team

Site Review Observations:

Investigation Files: The auditor reviewed three sexual abuse allegations for the past twelve months. One of the investigations was Staff-on-Resident and one investigation was Residents. The facility administrator provided the investigations to the auditor on the first day of the audit for review. The auditor reviewed two investigations provided by the facility to include an interview with the facility investigator. The auditor reviewed on case that was currently open and pending. The auditor reviewed the administrative investigation records, including retaliation monitoring for alleged victims, for incidents of sexual abuse and sexual harassment that were reported in the past 12 months immediately preceding the audit.

The facility had two investigators who are responsible for conducting all administrative investigations and all criminal investigations are forwarded to the local police department for further investigation. The facility reviewed the Grievances for the past 12 months and the facility had no grievances related to PREA. There were no records of criminal investigations pending during the audit. The investigation dispositions are shown below:

Description	Status	Criminal Case/Disposition	Criminal/Administrative
4. Resident-on-Resident	Unfounded	No case opened	Administrative
5. Staff-on-Resident	Unfounded	No case opened	Administrative
6. Staff-on-Resident	Pending/Open Case	Referred to CCPD	Administrative

Findings:

115.286 (a) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 23 section N. The auditor reviewed a total of three sexual abuse investigations. The required investigations had the Sexual Abuse Incident Review.

A. 14-02F CC Sexual Assault or Abuse Incident Review Form

B. PREA 5-1 Incident Reporting Definitions & 5-1E PREA Reporting

115.286 (c) The review team was coordinated with all the required team members. The facility has a good process in place utilizing for 14-2F CC Sexual Abuse or Assault Incident Review which requires detailed information for the overall assessment. The Facility Director was interviewed and explained the process of the SART team.

115.286 (d) The review team was coordinated with all the required team members. The facility has a good process in place utilizing for 14-2F CC Sexual Abuse or Assault Incident Review which requires detailed information for the overall assessment. The Facility Director was interviewed and explained the process of the SART team. The review team considers 1-6.

115.286 (e) The facility implements any recommended improvement and documents on the form.

Corrective Action:

Standard 115.287: Data collection

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

115.287 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? ☒ Yes ☐ No

115.287 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually? ☒ Yes ☐ No

115.287 (c)

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? ☒ Yes ☐ No

115.287 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews? ☒ Yes ☐ No

115.287 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) ☐ Yes ☐ No ☒ NA

115.287 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:

Primary:

A. Policy 14-2 CC Sexual Abuse Prevention and Response

Secondary:

1. 2017 CoreCivic PREA Annual Report

Findings:

115.287 (a/c) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 29 section T. Retention of Records CoreCivic Records Retention Schedule. CoreCivic website with the PREA Annual Reports.

115.287 (b) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 29 section T. CoreCivic Records Retention Schedule.

115.287 (d) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 29 section T. CoreCivic Records Retention Schedule. CoreCivic website with the PREA Annual Reports.

115.287 (e) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 30 section 2. CoreCivic Records Retention Schedule. CoreCivic website with the PREA Annual Reports.

115.287 (f) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 30 section 2. CoreCivic Records Retention Schedule. CoreCivic website with the PREA Annual Reports.

Corrective Action: The auditor recommends no corrective action.

Standard 115.288: Data review for corrective action

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

115.288 (a)

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

115.288 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse ☒ Yes ☐ No

115.288 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.288 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:

Primary:

A. Policy 14-2 CCSexual Abuse Prevention and Response

Secondary:

1. 2017 CoreCivic PREA Annual Report
2. CoreCivic webpage

Interviews:

1. Agency head
2. PREA Coordinator
3. PREA Coordinator

Findings:

115.288 (a) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 30 section 3. Annual Reports may be viewed on the public website: http://www.corecivic.com/facilities/corpus-christi-transitional-center.

115.288 (b) Annual Reports may be viewed on the public website: http://www.corecivic.com/facilities/corpus-christi-transitional-center.

115.288 (c) This report is approved by the agency head and Annual Reports may be viewed on the public website: http://www.corecivic.com/facilities/corpus-christi-transitional-center

115.288 (d) The agency may redact specific material from the reports prior to publication: Annual Reports may be viewed on the public website: http://www.corecivic.com/facilities/corpus-christi-transitional-center.

Corrective Action: The auditor recommends no corrective action.

Standard 115.289: Data storage, publication, and destruction

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

115.289 (a)

- Does the agency ensure that data collected pursuant to § 115.287 are securely retained? ☒ Yes ☐ No

115.289 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.289 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

115.289 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

Documentation Reviewed:

Primary:

A. Policy 14-2 CC Sexual Abuse Prevention and Response

Secondary:

1. PREA Annual Report 2017
2. CoreCivic Record Retention Schedule
3. CoreCivic.com website-The Prison Rape Elimination Act of 2003 (PREA)

Findings:

115.289 (a) Policy 14-2 CC Sexual Abuse Prevention and Response pg. 30. The agency ensures that the incident based, and aggregate data are securely retained.

115.289 (b) Annual Reports may be viewed on the public website: http://www.corecivic.com/facilities/corpus-christi-transitional-center.

115.289 (c) All personal information will be removed prior to public distribution. Annual Reports may be viewed on the public website: http://www.corecivic.com/facilities/corpus-christi-transitional-center.

115.289 (d) The agency maintains sexual abuse data collected pursuant to 118.87 for at least 10 years to include the Retention schedule.

Corrective Action: The auditor recommends no corrective action.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

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

115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*) ☒ Yes ☐ No

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard*.) ☐ Yes ☒ No

- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) ☒ Yes ☐ No ☐ NA

- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? ☒ Yes ☐ No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? ☒ Yes ☐ No

115.401 (m)

- Was the auditor permitted to conduct private interviews with residents, residents, and detainees? ☒ Yes ☐ No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CoreCivic Corpus Christi Transitional Center demonstrated compliance with the standard. The auditor reviewed all relevant agency-wide policies, procedures, reports, internal and external audits, and accreditations for the facility. The audits were reviewed, at a minimum, a sampling of relevant documents and other records and information for the recertification period. The auditor had access to all areas of the audited facility. The auditor was permitted to request and receive copies of any relevant documents (including electronically stored information).

The auditor shall retain and preserve all documentation (including, e.g., video tapes and interview notes) relied upon in making audit determinations. Such documentation shall be provided to the Department of Justice upon request. The auditor interviewed a representative sample of offenders, staff, supervisors, and administrators. The auditor reviewed a sampling of available surveillance cameras and other electronically available data that may be relevant to the provisions being audited. The auditor was permitted to conduct private interviews with residents. Residents were permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel. The auditor was able to communicate with community-based or victim advocates who may have insight into relevant conditions in the facility. The auditor concluded that the facility complies with the standard for the relevant recertification period.

Standard 115.403: Audit contents and findings

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

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CoreCivic Corpus Christi Transitional Center publishes reports on their agency website, and has otherwise made publicly available all Final PREA Audit Reports within 90 days of issuance by auditor. The agency website is : http://www.corecivic.com/facilities/corpus-christi-transitional-center.

The facility is compliant with the reporting process and standard for this recertification review period.

AUDITOR CERTIFICATION

I certify that:

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

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

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

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.[1] Auditors are not permitted to submit audit reports that have been scanned.[2] See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Noelda Martinez 5/7/19

Auditor Signature **Date**

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

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