PREA AUDIT REPORT ☐ Interim ☒ Final

COMMUNITY CONFINEMENT FACILITIES

Date of report: 6/13/2016

Auditor Information			
Auditor name: Tina E. Sallee			
Address: P.O. Box 373			
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Telephone number: 270-980-2430			
Date of facility visit: 5/19/2016			
Facility Information			
Facility name: Dismas Charities El Paso			
Facility physical address: 7011 Alameda, El Paso, Texas 79915			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 915-781-1122			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☒ Private not for profit		
Facility type:	☐ Community treatment center ☒ Halfway house ☐ Alcohol or drug rehabilitation center	☐ Community-based confinement facility ☐ Mental health facility ☐ Other	
Name of facility's Chief Executive Officer: Yvette Colorado, Director			
Number of staff assigned to the facility in the last 12 months: Redacted			
Designed facility capacity: Redacted			
Current population of facility: Redacted			
Facility security levels/inmate custody levels: Community			
Age range of the population: Adults 18-65			
Name of PREA Compliance Manager: Yvette Colorado		**Title:** Director	
Email address: ycolorado@dismas.com		**Telephone number:** 915 781-1122	
Agency Information			
Name of agency: Dismas Charities, Inc.			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: 2500 7th Street, Louisville, Kentucky 40208			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 502-636-2033			
Agency Chief Executive Officer			
Name: Jan Kempf		**Title:** Executive Vice-President/COO	
Email address: jkempf@dismas.com		**Telephone number:** 502-636-2033	
Agency-Wide PREA Coordinator			
Name: Joseph Theriot		**Title:** Regional Vice-President/PREA Coordinator	
Email address: jtheriot@dismas.com		**Telephone number:** 502-636-2033 ext. 1305	

AUDIT FINDINGS

NARRATIVE

Dismas Charities located at 7011 Alameda, El Paso, Texas is an (Redacted)-bed community confinement facility (halfway house) for men and women (current population is (Redacted) Federal offender residents (no State offenders) which is used to provide quality, cost-effective, community-based services and programs to individuals in the criminal justice system and assist them in becoming positive productive members of their community. The average length of stay is approximately (Redacted) days. The facility currently employs (Redacted) full-time staff (Redacted), majority of facility staff are bi-lingual in English/Spanish). The facility is constructed in one building with (Redacted) open bay/dorm housing units, housing unit doors open onto a central outdoor courtyard (outside recreation area). The facility has (Redacted) cameras (Redacted) that cover inside of building/outside of building. (Redacted).

This audit was conducted by DOJ Certified PREA Auditor Tina Sallee. During the Pre-Audit phase the auditor reviewed a variety of documents provided by the agency. These included policies and procedures, plans, protocols, training records, curricula, and other documents related to demonstrating compliance with the PREA Community Confinement Standards. The auditor did not receive any correspondence or requests from staff or residents prior to the on-site audit (a notice was posted with contact information for the PREA Auditor/audit date six week prior to the on-site audit).

An on-site PREA Audit was conducted on Thursday, May 19, 2016. A tour of the facility was conducted by the Regional Vice-President, Dan Judiscak and the Facility Director, Yvette Colorado. The on-site audit work plan was discussed, samples of residents and staff were selected, and specialized staff were identified. Also, additional pre-audit information was obtained. All areas of the facility were viewed including administration areas, conference area/meeting areas, CMO (Central Monitoring Office) that has monitor for (Redacted) cameras that cover inside of building/outside of building, (Redacted). PREA related informational posters in both English and Spanish were prominently posted and the PREA audit notice was also observed posted in the facility. Additionally, informational pamphlets and posters regarding PREA and crisis services were found where staff and residents had access. Pamphlets are also printed in English and in Spanish. No SAFE or SANE staff are employed at the facility; however, these professionals are provided at University Medical Center (the medical center is located on the same street as the facility) where forensic examinations would be conducted at no cost to the resident and/or their families.

Interviews were conducted with the Executive Vice-President/COO; the Regional Vice-President/Agency-Wide PREA Coordinator; the Regional Vice-President; the Facility Director; the Social Service Coordinator (that completes the Risk Assessment for Victimization and/or Abusiveness and includes orientation/education regarding PREA using video, pamplets, handouts and having residents sign an acknowledgement form that they have received the PREA information (all intake/orientation/risk assessment is completed within 24 hours of intake to the facility); one Counselor; and 4 residents (1 female and 3 male) (one male was limited English proficient and the Facility Assistant Director provided interpretation for PREA audit interview).

During the past 12 months, Dismas Charities reported zero (0) allegations/investigations of sexual harassment/sexual abuse. But the agency with authority to conduct criminal investigations would be Federal Bureau of Prisons and/or the local El Paso Police Department. Mental Health services can be provided by Community Treatment Services, Federal Bureau of Prisons Reentry Services Division, Residential Reentry Management Branch if needed.

The residents interviewed reported that they had been located in other adult correctional facilities before coming to Dismas Charities and had reportedly heard about/knew of PREA and were complimentary of their personal feelings about the safety and the security of this facility.

Documentation, staff and resident interviews confirmed that all residents do receive information on PREA and their right to not be sexually abused/harassed, how to report sexual abuse/harassment, their right not to be punished for reporting such immediately upon arriving at the facility during intake/orientation. Residents are assessed to ascertain risk of being sexually victimized and/or abusive and the facility uses this information to keep residents safe. Additionally, after residents are admitted into the facility they are provided additional information about sexual abuse/harassment. Residents who have experienced trauma, abuse, or victimization and/or request it are provided additional services as needed.

Staff and resident interviews occurred efficiently. The entire facility was toured. An exit conference was held including DOJ Certified PREA Auditor Tina Sallee; Regional Vice-President Dan Judiscak; Facility Director Yvette Colorado; and Facility Assistant Director Maria Tafoya. Overall, the facility was well prepared for the audit and performed well in all areas.

DESCRIPTION OF FACILITY CHARACTERISTICS

Dismas Charities is located at 7011 Alameda, El Paso, TX. The tour of the facilty was conducted by Regional Vice-President Dan Judiscak and Facility Director Yvette Colorado. The facility was housed in one main building with (Redacted) open bay/dorm housing units accessed by a central outdoor courtyard. There are currently (Redacted) cameras monitoring the facility and all cameras can be viewed at the Central Monitoring Office (CMO) by resident monitoring staff and by the Facility Director and by the Facility Assistant Director. The building is spacious enough for the staff and the residents. (Redacted). Cameras cover inside of building/outside of building with a monitor located in the Central Monitoring Office (CMO) and in both the Facility Director and Facility Assistant Director offices.

The PREA Audit notice and posters containing PREA information including the PREA hotline number are prominently posted on bulletin boards, dining area, hallways, classrooms/meeting rooms, and dorms.

The facility has made the following substantial expansions/modifications of existing facilities since August 20, 2012: (Redacted)

** All Information redacted is considered proprietary as it relates to contractual properties

SUMMARY OF AUDIT FINDINGS

The first PREA community confinement facility audit of the Dismas Charities was conducted on Thursday, May 19, 2016. The audit consisted of data review, staff and resident interviews and facility tour. Staff members were interviewed including the Executive Vice-President/COO; the Regional Vice-President/Agency-Wide PREA Coordinator; the Regional Vice-President; the Facility Director; one Counselor; the Social Service Coordinator. A number of residents were interviewed. Documents were timely and complete and included resident assessment forms, resident education acknowledgement forms as well as staff PREA training records. Staff and resident interviews occurred efficiently. The entire facility was toured. Overall, the facility was well prepared for the audit and performed well in all areas.

Number of standards exceeded: 4

Number of standards met: 31

Number of standards not met: 0

Number of standards not applicable: 4

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

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency and facility has a written policy mandating zero tolerance toward all forms of sexual harassment and/or sexual abuse in the Dismas Charities facility. The policy details the approaches it uses to prevent, detect and respond to sexual harassment and/or sexual abuse in the facility. The definitions of prohibited behaviors are clearly defined, as are the sanctions for those who violate the policy. Policy is thorough and mirrors the PREA language. Policy is in use and staff were able to explain it to the auditor when asked.

The agency has designated an Agency-Wide PREA Coordinator, Joseph Theriot, Regional Vice-President. He is very knowledgeable of PREA requirements/standards, devotes sufficient time and effort in assisting facility staff with PREA related topics, and has the authority to implement corrective actions. He reports that he has sufficient time and authority to coordinate the agency's/facility's compliance with the PREA standards.

Standard 115.212 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

NOT-APPLICABLE – this facility does not contract for the confinement of its residents.

Standard 115.213 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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In the past 12 months there has been zero (0) reports/investigations of sexual harassment/sexual abuse. Staff interviewed voiced that the physical layout of the facility, the composition of the resident population, and other relevant factors are used to calculate adequate staffing levels and to determine needs for further technologies, on an ongoing basis for the safety of the residents and the staff. There is a current camera/video monitoring system. The facility policy meets all the elements of the standard. The staffing plan has been completed and meets all the elements of the standard. Staff/resident interviews and documentation confirmed the practice of supervision and monitoring.

Standard 115.215 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Agency/facility policy states that staff are trained in cross gender pat down searches. All staff at time of audit had been trained. Agency/facility policy prohibits searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. This was confirmed during staff interviews.

All toilets have doors and all showers have curtains. Both review of policies and interviews with staff and residents confirmed that opposite gender staff announce their presence when entering into the dorm housing areas. Staff and resident interviews confirmed that this is the practice. None of the cameras field of view included toilet/shower areas.

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

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy has established procedures to provide residents with limited English proficiency equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual harassment/sexual abuse (the majority of facility staff are bi-lingual in English/Spanish). If it is determined that residents have limited reading skills, intake and/or screening staff will read the written materials to the residents.

Standard 115.217 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility conducts extensive background and reference checks. There is a facility policy to conduct background checks verified through documentation and staff interviews. The facility policy addresses all the elements of this standard. The Federal Bureau of Prisons must give written approval for employees before Dismas Corporate Office can approve a potential employee, the following paperwork is submitted to the Bureau of Prison Residential Reentry Office including but not limited to the Employment Application, Educational Verification, Reference Verifications, Authorization for Release of Information (Bureau of Prison Form), complete set of fingerprints for NCIC/NLETS Request Form (Bureau of Prison Form).

Standard 115.218 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility has made substantial expansion or modification to existing facility since August 2012 and interviews with the Executive Vice-President/COO, the Regional Vice-President/Agency-Wide PREA Coordinator, the Regional Vice-President, and the Facility Director confirmed that any and all modifications/updating to the facility is based on the practice of considering the effect upon the facility's ability to protect residents and staff from sexual harassment/abuse and/or allegations of sexual harassment/abuse.

Standard 115.221 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

(a)-(b) The facility does NOT conduct administrative or criminal investigations. The name of the agency that has responsibility would be United States Parole Office/Bureau of Prisons and/or El Paso Police Department. (c)-(g) The facility offers contact information for local Mental Health/Rape Crisis Center including Community Treatment Services, Federal Bureau of Prisons but forensic medical exams, when needed, would be conducted at University Medical Center at no cost to the resident or to their family.

Standard 115.222 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency/facility policy ensures that an administrative/criminal investigation is completed on all allegations of sexual harassment/abuse. The agency/facility policy requires that all allegations that are criminal in nature are reported to the United States Parole Office/Bureau of Prisons and/or El Paso Police Department, an agency with the legal authority to conduct criminal investigations.

Standard 115.231 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Documentation and staff interviews indicated that all current staff have completed PREA Training (training included all 10 elements of the subsection) and staff have signed acknowledgment forms (documentation through employee signature that employees received the training). That training is tailored to the gender of the residents and that staff can receive additional training if needed, that all employees are made aware of the agency's/facility's zero-tolerance for sexual harassment/abuse policies and procedures.

Standard 115.232 Volunteer and contractor training

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Agency/facility policy meets the requirements of the standard. The facility does utilize volunteers, vendors, and contractors, and they are all required to complete the PREA training. The facility maintains documentation/acknowledgement forms confirming that volunteers, vendors and contractors sign stating that they understand the PREA training that they have received on their responsibilities under the facility's

sexual harassment/abuse prevention, detection, and response policies and procedures. The facility utilizes volunteers including University students/interns for Social Work/Criminal Justice majors that are subject to the same extensive background and reference checks as employees before Dismas Corporate Office can approve placement.

Standard 115.233 Resident education

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency/facility policy is thorough and mirrors the PREA language. PREA education is conducted during orientation process with video, pamphlets, posters on bulletin boards, and documentation of the residents participation in these education sessions with resident signatures verifying they understand the facility's zero-tolerance policy regarding sexual harassment/abuse. Residents acknowledged during interviews they do receive the education upon entering the facility that they understood their rights to be free from sexual harassment/abuse and their right to be free from retaliation for reporting such incidents. Residents were able to discuss various ways they can report an allegation and/or receive services if needed. The agency/facility does provide residents education in formats accessible to all, including those who are limited English proficient or handicapped.

Standard 115.234 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

NOT-APPLICABLE. This facility does NOT conduct administrative or criminal investigations.

Standard 115.235 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

NOT-APPLICABLE. This facility does NOT employ full or part-time medical or mental health practitioners.

Standard 115.241 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Residents are screened for risk of sexual victimization and sexually abusive behavior. The screening instrument contains all 9 criteria to assess residents for risk of sexual victimization and sexually abusive behavior. Documentation of the screening instrument is maintained in each resident file and the facility reassesses the resident's risk of victimization or abusiveness based upon any additional relevant information received by the facility since the initial screening. No resident reported to the auditor that their personal information was used in any exploitative or inappropriate way. The facility policy strictly controls the dissemination of information gathered from the screening.

Standard 115.242 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Documentation and staff interviews indicate that the facility policy reflects PREA language. The facility does use information from the risk screening required by PREA Standard Number 115.241 to decide housing and program assignments with the goal of keeping all residents safe. To date there have been NO transgender or intersex residents admitted to the facility but staff have received training for the possibility in future if the need should arise regarding separate shower/housing/and programming assignments.

Standard 115.251 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Documentation, staff interviews and resident interviews indicate that the facility policy mirrors PREA language. Residents have multiple internal and external ways to privately report sexual harassment/abuse, retaliation by other residents or staff for reporting sexual harassment/abuse and/or staff neglect or violation of responsibilities that may have contributed to such reports. Staff interviews confirmed that staff can privately report sexual harassment/abuse of residents also. The facility policy is that all staff will accept reports made verbally, in writing, anonymously, and from third parties and promptly document any/all reports.

Standard 115.252 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility has an administrative procedure for dealing with resident grievances regarding sexual harassment/abuse. Documentation and staff interviews confirm the facility policy is in line with expectations in subsections: the facility does not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual harassment/abuse; the facility does not require a resident to use informal grievance processes with the staff of an alleged incident of sexual abuse; the facility ensures that all resident may submit grievance/grievance processes; the facility allows third parties, including family members, parole officers, and outside advocates to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse; the facility policy states that the facility may discipline a resident for filing a grievance related to alleged sexual abuse only where the agency demonstrates that the resident filed the grievance in bad faith.

Standard 115.253 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility utilizes the Federal Bureau of Prisons Reentry Services Division, Community Treatment Services to provide confidential emotional support for providing mental health assessment and counseling for those residents that fall under PREA while the resident resides in the Residential Reentry Center and/or on home confinement through the local Mental Health/Rape Crisis Center to provide victim advocate and supportive services to residents upon request. Posters/pamphlets containing contact information are given out during orientation process and posted throughout the building for resident and staff information/utilization. Resident interviews confirmed that residents are aware of these services and their right to make contact for services. Residents also have access to family members and parole officers.

Standard 115.254 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Documentation and interviews confirmed that the facility provides methods to receive third-party reports of resident sexual harassment/abuse and publicly distributes the information on how to report sexual harassment/abuse on behalf of others. PREA pamplets/posters are given to residents during orientation process and are also posted throughout the building for resident and staff information. Residents have access to family members and parole officers.

Standard 115.261 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

(a)-(e) The facility policy requires all staff to report/document immediately any knowledge, suspicion, or information regarding an incident of sexual harassment/sexual abuse that occurred in the facility; to report any retaliation against residents or staff for reporting such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident and/or retaliation.

Standard 115.262 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Documentation and staff interviews confirm that when the facility learns that a resident is subject to a substantial risk of imminent sexual abuse, the staff have been trained to take immediate action to protect the resident, including but not limited to separating the resident from potential abuser; notifying their supervisor, and completing documentation. All staff expressed that their primary responsibility at all times is the safety of all residents and staff in the facility.

Standard 115.263 Reporting to other confinement facilities

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

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

The facility policy and staff interviews confirm that upon receiving an allegation that a resident was sexually abused while confined at another facility, the Facility Director must notify the head of the facility/appropriate office at the agency where the sexual abuse is alleged to have occurred and requires notifying the appropriate investigative agency immediately.

Standard 115.264 Staff first responder duties

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

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

The facility policy and staff interviews confirm that policy does cover all required elements of staff first responder duties/training and staff could articulate the steps that they are to take when responding to an incident of sexual abuse.

Standard 115.265 Coordinated response

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

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

corrective actions taken by the facility.

The facility's detailed coordinated response plan and staff interviews confirm facility policy/training for actions required in response to an incident of sexual abuse among staff first responders, investigators, and facility/agency leadership.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

NOT-APPLICABLE. This facility does NOT participate in any collective bargaining agreements.

Standard 115.267 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Documentation and staff interviews confirm agency protection against retaliation and zero-tolerance for retaliation.

Standard 115.271 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Documentation and staff interviews confirm agency/facility policy is in line with the PREA Standard subsection language. The agency/facility policy requires that all allegations of sexual harassment or sexual abuse be referred for investigation to an agency with the

legal authority to conduct criminal investigations El Paso Police Department and United States Parole Office/Bureau of Prisons and/or administrative investigations (United States Parole Office/Bureau of Prisons). Investigations are conducted promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports; the credibility of an alleged victim, suspect or witness would be assessed on an individual basis and shall not be determined by the person's status as resident or staff; investigations include an effort to determine whether staff actions/failures to act contributed to the abuse; documentation is immediate and includes a description of the physical and testimonial evidence, investigative facts and findings; the facility retains all written reports; the departure of the alleged abuser or victim from the employment or control of the facility does not provide a basis for terminating an investigation; the facility cooperates with outside investigators and remains informed about the progress of any investigation until its conclusion/finding and is notified in writing.

Standard 115.272 Evidentiary standard for administrative investigations

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

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

Documentation and staff interviews confirm facility policy is in line with the PREA Standard language. The facility shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated for admininstrative investigations.

Standard 115.273 Reporting to residents

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

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

Documentation and staff interviews confirm facility policy is in line with the PREA Standard language, including but not limited to, the facility, following an investigation into a resident's allegation of sexual harassment/abuse reported/investigated in the facility, shall inform the resident as to whether the allegation has been determined to be "substantiated", "unsubstantiated", or "unfounded". If the agency did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the resident. All such notifications and/or attempted notifications shall be documented.

Standard 115.276 Disciplinary sanctions for staff

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Documentation and staff interviews confirms facility policy that staff who violate agency/facility zero-tolerance sexual harassment/abuse policies are subject to disciplinary action. Disciplinary actions include but are not limited to a variety of sanctions, including termination. The agency/facility policy requires all allegations of sexual abuse to be reported to law enforcement immediately regardless of whether the staff resigns or is terminated.

Standard 115.277 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Documentation and staff interviews confirm facility policy that all volunteers, vendors, and contractors are trained/sign an acknowledgment form stating that they understand the zero tolerance policy for sexual contact with residents and informed how to report any knowledge, suspicion, or information regarding sexual harassment/abuse that occurred in the facility directly to the Facility Director. Any volunteer, vendor and/or contractor who were to engage in sexual abuse would be prohibited from contact with residents and reported to law enforcement immediately.

Standard 115.278 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Documentation and staff interviews confirm facility policy that all residents shall be subject to disciplinary sanctions pursuant to a formal disciplinary process following a finding that the resident engaged in resident-on-resident sexual abuse.

Standard 115.282 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Documentation and staff interviews confirmed facility policy requires that all residents shall have access to unconditional, immediate emergency medical and mental health services at no cost to the resident and/or resident's family.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Documetation and staff interviews confirmed facility policy requires that all residents shall have access to unconditional ongoing medical and mental health care for sexual abuse victims (evaluation and treatment shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care (consistent with the community level of care) at no cost to the resident and/or the resident's family.

Standard 115.286 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Documentation and staff interviews confirmed facility policy identifies staff that serve on an Incident Review Team that does include upper-level management officials, with input from the Regional Vice-President; the Facility Director, the Facility Assistant Director, the Social Service Coordinator, the Counselors, and the Resident Monitors. The review team considerations of all allegations include but are not limited to the following: whether the allegation or investigation indicated a need to change policy or practice to better prevent, detect, or respond to sexual abuse; whether the incident or allegation was motivated by race, ethnicity, gender identity, status or perceived status, or whether it was motivated or otherwise caused by other group dynamics in the facility. The review team examines the area where the incident allegedly occurred to assess physical layout; assess the adequacy of staffing level in that area during different shifts; and assess whether monitoring technology should be improved/upgraded. The review team documents its findings.

Standard 115.287 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Documentation and staff interviews confirmed agency policy that requires facility collect accurate, uniform data for every allegation of sexual harassment/abuse at the facility using a standardized instrument and set of definitions provided by Agency/Corporate. The facility does maintain, review and collect data as needed from all available incident-based documents and provides reports annually for Bureau of Prisons and at least annually at the corporate level (also upon request when necessary).

Standard 115.288 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Documentation and staff interviews confirmed facility policy to review data collected pursuant to PREA Standard 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training including but not limited to identifying problem areas, taking corrective action on an ongoing basis, and preparing an annual report of its findings to United States Federal Bureau of Prisons and the Agency/Corporate level Dismas Charities, Inc. The facility report is approved by the agency head.

Standard 115.289 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Documentation and staff interviews confirmed agency/facility policy that ensures data collected to PREA Standard 115.287 are securely retained. The facility removes all personal identifiers and maintains sexual abuse data collected for at least ten (10) years after the date of the initial collection.

AUDITOR CERTIFICATION

I certify that:

- ☒ The contents of this report are accurate to the best of my knowledge.
- ☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- ☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Tina Sallee 6/13/16

Auditor Signature Date