PREA AUDIT REPORT D Interim 181 Final
COMMUNITY CONFINEMENT FACILITIES

Date of report: 06/05/17

Auditor Information			
Auditor name: Patrick J. Zirpoli			
Address: [redacted]			
Email: [redacted]			
Telephone number: [redacted]			
Date of facility visit: 05/09/17			
Facility Information			
Facility name: Syracuse Pavilion			
Facility physical address: 701 Erie Blvd. East, Syracuse, NY 13210			
Facility mailing address: *(if different fromabove)*			
Facility telephone number: 315-442-5949			
The facility is:	D Federal D Military	D State D Municipal	D County D Private for profit
	181 Private not for profit		
Facility type:	D Community treatment center 181 Halfway house D Alcohol or drug rehabilitation center	D Community-based confinement facility D Mental health facility D Other	
Name of facility's Chief Executive Officer: Chris Corcoran			
Number of staff assigned to the facility in the last 12 months: 17			
Designed facility capacity: 36			
Current population of facility: 27			
Facility security levels/inmate custody levels: minimum security/parole status			
Age range of the population: 18 yrs. and older			
Name of PREA Compliance Manager: Chris Corcoran		Title: Facility Director/PREA Compliance	
Email address: ccorcoran@firetree.com		Telephone number: 570-601-0877 ext. 2803	
Agency Information			
Name of agency: Firetree, LTD			
Governing authority or parent agency: NA			
Physical address: 800 West Fourth Street Williamsport, PA 17701			
Mailing address: NA			
Telephone number: 570-601-0877			
Agency Chief Executive Officer			
Name: Ron Magargle		**Title:** Chief Operating Officer	
Email address: rmagargle@firetree.com		**Telephone number:** 570-601-0877 ext. 2007	
Agency-Wide PREA Coordinator			
Namc: Steven McCardell		Title: Compliance Officer	
Email address: smccardell@firetree.com		Telephone number: 570-601-0877 ext. 2013	

AUDIT FINDINGS

NARRATIVE

The Prison Rape Elimination Act (PREA) audit of Syracuse Pavilion took place on May 9, 2017. The purpose of the audit was to determine compliance with the Prison Rape Elimination Act standards which became effective August 20, 2012. The facility was posted on March 27, 2017, allowing adequate time for staff and residents to respond to me in writing. Prior to the onsite portion of the audit I reviewed all policies and data pertaining to the PREA Standards. A flash drive with all pertinent documentation and policies pertaining to the facility was received by me on April 21, 2017, allowing ample time to review the documentation prior to the onsite portion of the audit.

I wish to extend my appreciation to Facility Director Chris Corcoran, PREA Coordinator Steven McCardell, Corporate Counsel George Bishop, and all of the staff at the Syracuse Pavilion for the professionalism they demonstrated throughout the audit and their willingness to comply with all requests and recommendations made.

The audit began on the morning of May 9, 2017. The audit consisted of an extensive facility tour, with all areas being viewed, and random interviews with staff, and residents. I had the opportunity to observe the operations of the facility, and the interaction between staff and residents.

During the interview portion of the audit ten formal staff interviews were conducted, as well as in depth discussions with other staff available during the tour. Included in the interviews were the Chief Operating Officer, Corporate Counsel, Agency PREA Coordinator, Facility Director/PREA Compliance Manager, Counselors, Social Service Coordinator, Program Monitors, Maintenance, and Kitchen Staff. The staff interviewed were randomly selected.

Also during the interview portion ten of the residents at the facility were interviewed. I selected the residents by obtaining a population sheet, and randomly selected the residents from all housing units.

All of the interviews were conducted in a very efficient manner, this was accomplished by the efforts of all staff of Syracuse Pavilion, but more specifically Facility Director Chris Corcoran.

The facility was prepared for the onsite audit and performed extremely well. Looking at the overall performance of the facility I was impressed with not only the facilities operations but the overall agencies operations and response to incidents of sexual abuse or sexual harassment. The seriousness of incidents of this nature are not overlooked by both staff and residents alike. The interactions with the staff were positive and all were extremely helpful in making the audit process run as seamless as possible.

I coordinated the audit with Agency PREA Coordinator Steven McCardell. It was through this coordination that the audit process went as smoothly as possible.

The agency level interview conducted by phone with COO Ron Magargle

I utilized an overall methodology to make my determination of compliance with the standards. This included a complete review of all policies and documentation provided to me prior to the onsite audit. The documentation was then corroborated through visual inspection of the facility, as well as interviews with staff and residents. I was able to determine that the facility has the policies in place to address all standards, and has put these policies into daily practice. In the standard-by-standard discussion I have specifically identified the policies and documentation utilized during this process, these policies and documentation are listed verbatim in italic type. I have also listed any visual evidence, as well as interviews that aided in making my determination.

DESCRIPTION OF FACILITY CHARACTERISTICS

Syracuse Pavilion is located at 701 Erie Blvd. East, Syracuse, NY 13210. The facility houses both male and female residents placed by the Federal Bureau of Prisons. The facility is located within the city limits of Syracuse, this allows the residents to utilize public transportation, and is extremely advantageous for job seeking. The immediate area surrounding the facility is best described as commercial.

To gain access to the facility all staff, visitors and returning residents must enter through the main entrance, access is controlled by staff and is secured at all times. The main entrance area is surveilled by a camera, allowing staff to visually identify individuals before access is granted. The building is a single story structure. Upon entering the facility all persons need to clear the metal detector, and all personal property argis searched. The facility has the capability to house four female residents and thirty two male residents. The monitor's station is located in the center of the building allowing constant visual supervision of the main hallway. The males and females are housed at opposite ends of the building. The main corridor has offices, recreation rooms, kitchen, dining room, and storage rooms. The female housing area contains four beds, a bathroom is located off of the housing area. The male housing area contains thirty two beds, a counselor's office, and the bathroom. The bathrooms have stall doors and shower curtains to provide adequate privacy.

All areas of the facility are under direct supervision of staff. The monitor station is placed to allow adequate staff supervision.

During the facility tour I observed multiple staff moving throughout the facility.

During the past 12 months 75 residents have been admitted to the facility, with 72 staying for 72 hours or more, and 65 staying for 30 days or more. 55 residents came from other confinement settings. The average length of stay at the facility is 120 days.

SUMMARY OF AUDIT FINDINGS

Syracuse Pavilion has exceeded in 6 standards, met 30 standards, and 3 standard is not applicable to the facility.

This determination was made after reviewing all materials provided during the pre-audit, the interviews and facility tour conducted during the audit, and the final review of all findings.

Number of standards exceeded: 6

Number of standards met: 30

Number of standards not met:

Number of standards not applicable: 3

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

181 Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

Policy and Procedures Manual Policy # 12-001 Subject: Zero Tolerance of Sexual Abuse and Sexual Harassment establishes the agencies policy against sexual abuse and sexual harassment. The policy reads as follows:

Policy:
Firetree, Ltd. mandates zero tolerance towards allforms of sexual abuse and sexual harassment. Measures are developed and implemented in order toprevent, detect, and respond to sexual abuse and sexual harassment conduct.

Scope: Thispolicy is applicable to the governing body, allfacility employees, all residents underfacility supervision, volunteers, contractors, interns, visitors, and to all those individuals and groups that conduct business with or use resources of the company.

A. Zero Tolerance Policy:

"Zero tolerance" means that no sexual abuse or sexual harassment is tolerated, including abuse by residents and by staff.

- *No one has the right toforce orpressure a resident to engage in sexual acts. Residents do not have to tolerate sexual abuse orpressure to engage in unwanted sexual behavior regardless of age, size, race, or ethnicity. Whether one is straight, gay, lesbian, bisexual, transgender, gender non-conforming or intersex, has no bearing on the right to be sqfe from unwanted sexual advances and acts.*

- *A resident, employee, contract service provider, visitor, volunteer, intern and/ or individual who has business with or uses the resources of Firetree, Ltd. is subject to disciplinary action and/ or sanctions, including possible dismissal and termination of contracts and services, if he/ she isfound after an investigation to have engaged in sexual harassment or sexual abuse with a resident.*

- *Anyone who engages in,fails to report, or knowingly condones sexual harassment or sexual abuse of a resident shall be subject to disciplinary action, up to an including termination, and may be subject to criminal prosecution.*

- *A claim of consent will not be accepted as an affirmative df{fense for engaging in sexual harassment or sexual abuse of a resident.*

I reviewed 1he Policy in its entirety, as well as questioned staff members on its content and applicable sections to their specific duties within the facility. The staff understood the policy and its practical application to the daily operation of the facility.

The policy is comprehensive and mandates zero tolerance toward all forms of sexual abuse and sexual harassment and outlines the agency's approach to preventing, detecting, and responding to such conduct. The policy further

defines all prohibited acts.

The agency employs Steven McCardell as the agency-wide PREA coordinator. During his interview he related that he has sufficient time and authority to develop, implement, and oversee agency effmts to comply with the PREA standards in all of its community confinement facilities.

I found the Facility Director to be well versed in the PREA Standards, but more importantly their practical application to the everyday running of the facility.

Standard 115.212 Contracting with other entities for the confinement of residents

D Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

The agency does not contract with other entities for confinement of residents.

Standard 115.213 Supervision and monitoring

D Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

Policy and Procedures Manual Policy # 12-003 Subject: Supervision and Monitoring establishes the facilities staffing plan. The policy reads as follows:

Policy: Firetree, Ltd. shall develop, document, and review at least annually the staffing and video monitoring plan for eachfacility to assess resident protection against abuse.

Procedures:

1. *In calculating adequate staffing levels and determining the need for video monitoring, agency shall take into consideration thefollowing elements:*

    - *thephysical layout of eachfacility*
    - *the composition of the resident population*
    - *theprevalence of substantiated and unsubstantiated incidents of sexual abuse; and*

- *any other relevantfactors*

2. *Whenever necessary, and at least annually, in collaboration with the PREA Coordinator and* COO, *the staffing and video monitoring plan is reviewed to determine if any adjustments is needed in*

    - *Prevailing staffing patterns*
    - *the deployment of monitoring systems and other monitoring technologies*
    - *the resources thefacility has available to commit to ensure adequate staffing levels*

3. *Any deviationfrom the staffing and monitoring plan must be documented andjustified.*

4. *PREA administrative tours must be conducted by management level employees to identifY and deter staff sexual abuse and sexual harassment. These tours are unannounced and are conducted once each shift at varied times, every month. They may be conducted more often if there is an identified need.*

    - *shifts are defined at 0600-1400; 1400-2200; 2200-0600*
    - *the PREA Compliance Manager must participate in at least one tour every month*
    - *the PA Department of Corrections Contract Facility Coordinator must participate in at least one tour every month*

5. *Steff conducting the tour shall:*

    - *Not inform anyone that these tours are occurring. Any staff memberfound to be alerting other staff to these unannounced rounds will be subject to disciplinary action*
    - *Pay particular attention to the staff and video monitoring of thefacility to detect areas that may need enhancement to ensure the sexual safety f thefacility*
    - *Talk with staff and inquire aboutperceived areas of concern related to PREA or relating to any problem residents related to PREA*
    - *Focus on any and all areas of thefacility where there could be a potential for residents to become victim f sexual abuse*

6. *The PREA Compliance Manager shall ensure that each tour isproperly documented on the PREA Administrative Tour Report*

The facility has developed a staffing plan to provide adequate levels of staffing, and where applicable, video monitoring, to protect residents against sexual abuse and sexual harassment. During my interviews with the Facility Director and PREA Coordinator I determined that the facility layout, composition of the resident population, any incidents of sexual abuse or sexual harassment, and any other relevant factors were utilized in developing the staffing plan.

The facility director constantly evaluates the staffing plan, staffing patterns, deployment of video monitoring and available resources. This was discussed during the interview and confirmed.

The facility staffing has not been deviated from during the last 12 months.

I reviewed the staffing plan in its entirety and found that it complies with all aspects of the standard.

I was able to view the overall camera placement in the facility as well as the surveillance system monitors. I found that the facility is adequately covered by these cameras.

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)

EVIDENCE OF COMPLIANCE:

Policy and Procedures Manual Policy # 12-004 Subject: Cross Gender Viewing and Searches established the policies for conducting cross gender searches, and cross gender viewing. The policy reads as follows:

Subject: Cross-Gender Viewing and Searches

Scope: Thispolicy is applicable to the governing body, allfacility employees, all residents underfacility supervision, volunteers, contractors, interns, visitors, and to all those individuals and groups that conduct business with or use resources of thefacility.

Policy: Body cavity searches and cross-gender strip searches are strictly prohibited. Cross-gender pat-down searches offemale residents are also prohibited.

Definitions:
Exigent circumstances -any set of temporary and unforeseen circumstances that require immediate action in order to combat a threat to the security or institutional order of afacility.

Procedures:

Cross-gender searches

1. *Firetree, Ltd. shall strictly prohibit body cavity searches and cross-gender strip searches.*

2. *Stqff shall be trained to conduct all resident searches in a professional, respectful, and least intrusive manner possible, consistent with security needs.*
   - *Female stqff shall be trained to conduct cross-gender pat-down searches of male clients. Cross gender pat-down searches of female residents by male staff isprohibited.*
   - *Staff shall be trained 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.*

3. *Staff are prohibited from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. If the resident's genital status is unknown, it may be determined 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.*

4. *Thefacility shall not restrictfemale residents' access to regularly available programming in order to comply with the cross-gender pat-down prohibition regardingfemale residents.*

5. *If an exigent situation arises that leads staff to believe that there is imminent risk to staff or overall security of thefacility, staff will contact the local police for assistance. An example of this would be reputable information received regarding thepurported presence of a weapon on a*

resident.

Cross-gender Supervision

1. *A reasonable attempt must be made to ensure that there is at least one staff person, trained in search procedures, of the same gender as resident population is on duty at all times.*

2. *When the status quo of the gender-supervision on the housing unit changes from exclusively same gender, to mixed gender or cross-gender supervision, staff is required to verbally announce the presence of opposite gender person(s) on the housing unit. The announcement is required for all staff, volunteers, visitors, contractors, vendors, and interns. For example, male staff entering a female housing unit shall announce "male on floor". Housing area announcement signs shall be posted at the entrances to resident housing areas.*

Residents shall be able to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances. Locations shall be designated that allows residents to shower, perform bodily functions and change clothing with basic privacy. Staff of the opposite gender shall announce their presence prior to entering a bathroom area, shower area, or authorized changing area. "Authorized changing area" signs shall be posted at all facility locations throughout the facility that allows residents to shower, perform bodily functions and change clothing with basic privacy. These signs have the wording that staff of the opposite gender shall knock and announce themselves before entering the area. (For example: "Female entering

The facility does not conduct cross-gender searches, this includes pat down searches, strip searches and visual body cavity searches. This was confirmed during the interviews with both random staff and residents.

The facility has implemented policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nomnedical 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. These policies and procedures require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing. I reviewed the policy in its entirety, refer above facility policy. During the facility tour I observed staff of the opposite gender making announcements when entering residents housing and bathroom areas. I was also able to corroborate this practice during the random resident and staff interviews, all who were interviewed related that staff of the opposite gender announce their presence.

The facility does not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status. All residents received at the facility are coming from another facility so their gender is identified prior to arrival. If exigent circumstances existed all staff interviewed understood that gender should be detennined through 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. The facility has not housed a transgender nor intersex resident within the last 12 months.

The facility is staffed with one male monitor and one female monitor at all times, this alleviates cross gender viewing and searching issues.

The facility has not performed a pat down search of a transgender or intersex resident for the sole prupose of determining the residents sex.

The agency has trained security staff on how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a professional and respectful mailller, and in the least intrusive manner possible, consistent

with security needs. This was verified through visually inspecting the training records and during the random staff interviews.

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

D Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

Policy and Procedures Manual Policy # 12-005 Subject; Resident Disabilities and English Proficiency establishes the policies for handling residents who have disabilities or are not English proficient. The policy reads as follows:

Subject: Resident Disabilities and English Proficiency

Scope: Thispolicy is applicable to the governing body, al/facility employees, all residents under facility supervision, and to all those individuals and groups that conduct business with or use resources of thefacility.

Policy: The agency shall take steps to ensure that residents with disabilities will receive an equal opportunity to participate in or benefit.from all aspects of the agency's efforts toprevent, detect, and respond to sexual abuse and sexual harassment. Disabilities include deaf nr hard of hearing, those who are blind or have low vision, and those who have intellectual, psychiatric, or speech disabilities.

Access to Information for Special Populations:

I. All staff shall be trained on PREA compliant practices for residents with disabilities. This training shall be documented.

2. Written materials will either be delivered in alternative formats that accommodate the resident's disability or through methods that ensure effective communication with residents with disabilities including residents that have intellectual disabilities, limited reading skills, or who are blind or have low vision. Information will be delivered through alternative methods.

3. Steps shall include, when necessary to ensure effective communication with residents who are deaf or hard of hearing, providing access to interpreters who can interpret or communicating through an interpreter who can interpret effectively, accurately, and impartially, both receptive!y and expressively, using any necessary specialized vocabulary to ensure the understanding of the PREA related material. Alternate delivery methods include:

- *Reading the material to the resident,*
- *Allowing an opportunity to have the information provided twice,*
- *Utilizing the Spanish version of the "Speaking Up Video"*
- *Utilizing the Speaking Up Video closed caption option*
- *Utilizing the Speaking Up Video transcript*
- *Utilizing available interpretation services.*

4. Letters of agreement shall be established with special needs supportive services such as language translation.for residents that are limited English proficient, or specialization.for residents that are decifl hard

of hearing.

5. The PREA Compliance Manager will ensure that only staff members or qualified contractors provide translation for residents.

6. Resident interpreters, resident readers, or other types of resident assistants are prohibited except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance offirst responder duties, or the investigation of the resident's allegation. Theprogram documents the limited circumstances in individual cases where resident interpreters, readers, or other types of resident assistants have been used.

The facility has procedures in place to deal with residents with disabilities and who are limited English speaking. They have never had an incident where they would utilize another resident for interpretation, they would utilize staff or a language line. During the classification of the residents they identify any issues concerning disabilities and take the appropriate actions needed to protect the resident. The facility is equipped to ensure meaningfol 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, including steps to provide interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary.

Compliance in this area was determined by reviewing policies and procedures of the facility. During the random staff interviews I determined that they all understood the availability of interpreters, and farther understood the importance of not utilizing residents for interpretation during any incident.

The agency has an agreement with Alliance Business Solutions LLC to provide translation if needed.

The facility provides both English and Spanish versions of the educational materials.

At the time of the audit no disabled or non-English speaking residents were being housed.

Standard 115.217 Hiring and promotion decisions

D Exceeds Standard (substantially exceeds requirement of standard)

t:8I Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

Policy and Procedures Manual Policy # 12-006 Subject: Hiring and Promotion Decisions establishes the policies for hiring and promotions. The policy reads as follows:

Scope: Thispolicy is applicable to the governing body, allfacility employees, and contractors.

Policy:

Each staff member is required to undergo an initial criminal history clearance check. Additional criminal history checks will be conducted every twoyears when contractually required, and at a period no longer thanfive years for employees and contractors that may have contact with residents. All prospective employees who reside, orwho

have resided, worked, or attended school outside of Pennsylvania for any period of time cifter the age of 18, are required to obtain a criminal history clearancefrom the FBI in addition to the Pennsylvania state criminal history. No staff member will be permitted to begin employment before the results of their initial criminal history clearance check are received and reviewed, and that best efforts are made to conduct prior institutional employment reference checks that are in accordance with this policy. We do not accept criminal history clearances from applicants nor do we hire applicants on a provisional basis under Act 80.

Firetree, Ltd. prohibits hiring or promoting anyone who may have contact with residents and prohibits enlisting the services of any contractor who may have contact with residents who:

- *Have engaged in sexual abuse in a prison, jail, lock-up, community confinement facility, juvenile facility, or other institutional (as defined n 42 US.C. 1997);*
- *Have been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats offorce, or coercion, or if the victim did not consent or was unable to consent or refuse; or*
- *Have been criminally or administratively adjudicated to have engaged in the activity described above.*

Procedure:

Any incidents of sexual abuse and sexual harassment are considered in determining whether to hire or promote anyone or to enlist the services of any contractor who may have contact with the residents.

Prior to approval of the hire or promotion of an individual:

1. *The Facility Director, or designee, conducts an in-depth interview with theperspective employee. The applicant shall be asked directly about previous misconduct pertaining to the exclusionary categories listed above either through written applications or hiring or promotion interviews, or through written self-evaluations considered as part of current employee review.*
2. *Applicants are informed by the staff conducting the interview that an NCIC background check will be conducted.*
3. *The background check is conducted accordingly, and the results are reviewed to determine that the individual does not meet any of the hire orpromote prohibitions listed above.*
4. *Consistent withfederal, state, and local law, thefacility makes is best efforts to contact all prior prison institution employers.for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse.*

Prior to enlisting the services of any contractor who may have contact with residents, thefacility conducts a criminal background check to ensure the contractor does not meet any of the prohibitions listed above.

Employees have a continuing affirmative duty to disclose any such sexual abuse or sexual harassment misconduct.

Material omissions regarding such misconduct, or theprovision of materially false information, shall be grounds for termination.

Unlessprohibited by law, information shall beprovided on substantiated allegations of sexual abuse or sexual harassment involving a.former employee upon receiving a request from an institutional employer/or whom such employee has applied for work.

A. initial Background Checks

The Facility Director or designee completes an interview of the potential candidate for employment.

Upon selecting an individual.for employment, the department supervisor has the candidate complete an employment application along with the required Background Check Forms.

Following completion of the appropriate Background Check Forms, the department Supervisor reviews the.forms for accuracy.

The department supervisor.forwards the completed applications to the Director of Administration or designee upon the decision to hire a candidate.

The Director of Administration or designee reviews theforms to determine that they have been completed in their entirety.

The Director of Administration or designee distributes the completed forms to the.following Organizations, as contractually applicable:

For federal programs, the Federal Bureau of Prisons clearance data request report isfaxed to the Community Correction Manager's office. Each new employee isfingerprinted as part of the.federal clearance process. Staff mails the completed fingerprint card to the Federal Bureau of Prisons Community Corrections Manager's Office. The Federal Bureau of Prison will review the clearance results and will not!fY the program as to whether or not the individual is approved to work with federal offenders.

The State Police Clearance Check is completed on-line by the Director of Administration, or designee via the PATCH System (Pennsylvania Access to Criminal History). Clearances via this site are either immediately reported as either NO RECORD or RECORD PRNDTNG. Should a Record PENDING status be given it will take approximately 7 - I 0 days for the State Police to complete a second check and complete the record which will then be mailed to thefacility. Upon receipt of this check, the status will either be NO RECORD or the criminal history will be enclosed. Upon receipt of the record, the initialform, record check with either NO RECORD or the criminal History is.faxed to the Department of Corrections, Regional Office in Harrisburg. The PA Department of Corrections will review the results and will notifY theprogram as to whether or not the individual is approved to work with offenders under theirjurisdiction.

The amount ()f time it takes to receive results backfrom any particular agency may vary. It is expected that it will take approximately 1 - 2 weeks until all background checks have been completed and returned to thefacility.

Thefacility administrative staff are required to monitor record and reportfindings to the Director of Administration. Facility Administrative Staff will initiate a background check on all staff every two years when contractually required, and at a period no longer than 5 years for current employees and contractors who may have contact with residents.

B. Re-Certification of Background Checks

The Director of Administration or designee maintains a staff rosterfor the purpose of tracldng all employee background check status.

The Director of Administration is *required to update the roster with all pertinent Human Resource information upon the individual's employment with the organization.*

Each month the Director of Administration or designee posts a printed listing that refleets all employees that will need to be scheduled for a second year re-certifications of backgrounds or a no longer than 5 year period re-certification.

The Facility Director utilizes the monthly list to determine which individual employees are required to have the second year review or a no longer thanfive year review.

The Director of Administration or designee contacts each individual on the list when re-certifications are due and schedules the opportunity to complete and review the appropriate forms.

The Director of Administration or designee ensures the background checks are completed and the results are recorded in the personnel file.

Forfederal programs the Federal Bureau of Prisons will complete employee background re-checks on all employees in contracted programs in accordance with thefederal contract.

C. *Maintenance of Information:*

The Director of Administration and/or designee is required to maintain all completed background checks and pertinent information in the employee's confidential personnel file.

During the agency interviews the hiring process for all employees was confirmed. The agency has an in depth and comprehensive hiring practice. All potential new employees are subject to a hiring process which includes a criminal history background check, and questions asked relative to sexual misconduct. This practice is also utilized in enlisting the services of any contractor, and allowing volunteers to enter the facility. These procedures are also used in the promotion system.

The employees must pass a background clearance through the Bureau of Prisons upon issuance of the contract, the contract period is for five years. The current background checks were completed in November of 2015. This information was confirmed with the Agency PREA Coordinator.

Standard 115.218 Upgrades to facilities and technologies

D Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

No upgrades are scheduled at the facility.

Standard 115.221 Evidence protocol and forensic medical examinations

D Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

Policy and Procedures Manual Policy # 12-008 Subject: Access to Emergency Medical & Mental Health Services, Forensic Medical Examinations, and Victim Advocate Services, and Follow-up Services. This policy reads as follows:

Scope: Thispolicy is applicable to the governing body, allfacility employees, all residents underfacility supervision, and to all those individuals and groups that conduct business with or use resources of thefacility.

Policy: Resident victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined cy *medical and mental health practitioners according to their professional judgment. Victims of sexual abuse shall be offered access to aforensic medical examination, and medical and mental health sexual abuse follow-up services.*

Procedures:

1. *Upon learning of an allegation that a resident was sexually abused, thefirst staff member to respond shall take immediate and appropriate steps to ensure the resident's safety and actions to maximize the potential for obtaining usable physical evidence in accordance with Staff First Responder Duties Policy 12-018.*

2. *The PREA Compliance Manager (PCM) shall coordinate medical services related to sexual abuse for theirfacility and where possible, utilize a hospital that employs a Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE).*

3. *Letters of agreement shall be maintained for forensic medical examinations* cy *Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs).*

4. *Staff shall not take any photographs when a sexual abuse allegation is made. The collection of any photographic evidence must be conducted by the outside medical professional or law enforcement.*

5. *On-site medical staff shall not conductforensic medical exams of residents.*

6. *In orderfor aforensic medical examination to beperformed, the report must be made within 96 hours of the abuse happening. Theforensic examination will occur at the hospital in an attempt to try to collect any possible evidence that may be present. Because of this, there are several things that one needs to keep in mind.*

- *Even though one may want to clean up after the abuse, it is important to see supervisory staff BEFORE one showers, washes, drinks, eats, smokes, changes clothing, or uses the bathroom.*
- *Hospital medical staff will examine the residentfor injuries, which may or may not be readily apparent to the resident.*

7. *Forensic medical examinations shall be offered to all victims of sexual abuse, withoutfinancial cost, where evidentiary and medically appropriate. No financial liability is assumed by Firetree, Ltd. as sexual abuseforensic examinations arefunded in accordance with CFR Title 28, Chapter 1 Part 90 Subpart B, Section 90.14.*

8. *The PREA Compliance Manager shall coordinate victim services related to theirfacility.*

9. *The PCM shall work with the Pennsylvania Coalition against Rape (PCAR) approved local rape crisis center to establish a Rape Crisis Letter of Agreement for victim advocate and emotional supportive services. These services shall be offered to all sexual abuse victims.*

I 0. Notification about available services (attachment 4-C) shall be posted in the facility common areas accessed by residents. The posting shall include the address for local services, and phone numbers, including toll-free hotline numbers where available, with written consent of the organization providing the services. The facility shall enable reasonable communication between residents and these organizations in as confidential a manner as possible. The facility shall not monitor these communications.

11. If the victim refuses to go to the hospital for forensic examination, the rape crisis center will be asked to help in the matter. Normally with client consent, a rape crisis victim advocate will meet the client at the hospital in the provision of victim advocate services.

12. The PREA Compliance Manager (PCM) or designee will accompany the resident during transport to a hospital. The PCM does not necessarily have to travel in the ambulance with the victim, however at a minimum should meet the victim at the hospital. The purpose of the PCM presence is to provide emotional support to the victim by sitting with the victim at the hospital and to ensure the proper coordination with the victim advocate service. The PCM shall not be present in the forensic examination room. It is permissible upon request from the victim, to allow the victim's family to provide the transport to the hospital.

13. With the resident's consent, the hospital staff can also test and provide treatment for sexually transmitted infections, possible exposure to diseases such as HIV and Hepatitis, and gather any physical evidence of abuse.

14. Females may be tested for pregnancy at the hospital when appropriate.

15. Residents who are victim of an abuse by staff or other resident(s) may seek counseling and/or advice from a psychologist or chaplain. Crisis counseling, coping skills, suicide prevention and mental health counseling are to be available to the resident. M ost individuals need help to recover from the emotional effects of sexual abuse. Rape crisis victim advocates serve to accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support; crisis intervention, iriformation, and referrals.

16. To the extent Firetree, Ltd. itself is not responsible for investigating allegations of sexual abuse it shall request that the investigating agency follow the requirements set forth in this policy. This request shall be documented.

Follow-up Services:

I . The PCM shall coordinate medical and mental health evaluations and, as appropriate, treatment for all residents who have been victimized by sexual abuse in any prison, jail, lockup, juvenile facility, or community confinement facility. This includes follow-up services, treatment plans, and referrals for continued care following their release from the facility.

2. The PCM shall coordinate medical services and referrals for treatment in the community, in accordance with pr(J fessionally accepted standards, to include: (Jffered pregnancy tests for resident victims of sexually abusive vaginal penetration during incarceration, timely and comprehensive information about and access to emergency contraception; lawful pregnancy-related services (if pregnancy results from sexually abusive vaginal penetration); Sexually Transmitted Infections (ST!) testing and follow-up treatment.

3. Medical and mental health r<ferrals shall occur to locations providing servicers consistent with the

community level of care.

4. *Thefacility shall attempt to have a mental health evaluation conducted of all known resident-on-resident abusers within 60 days of learning such abuse history and offer treatment when deemed appropriate by mental healthpractitioners.*

5. *Services shall beprovided withoutfinancial cost to the victim regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Thisfinancial obligation ends when the resident is releasedfrom thefacility.*

Any incident would be investigated by the Bureau of Prisons Office of Inspector General, Internal Affairs, these investigators are tasked with investigating the administrative investigation. Ifthe investigation is criminal the Syracuse Police Department would conduct the criminal investigation. The investigating process was confirmed with the BOP Residential Re-entry Manager.

The facility utilizes Vera House Rape Crisis Center for both victim advocacy and Sexual Assault Nurse Examiners (SANEs) to conduct the forensic examination. The SANE will be dispatched to St. Joseph's Hospital Health Center if an incident occurs.

During the interview with the Facility Director I confirmed that the above services are being utilized for forensic examinations. I was informed that the facility has had no incidents where these services were utilized.

The facility has a MOU with Vera House, this MOU is dated April 28, 2015.

All of the staff interviewed understood their responsibility in the preservation of evidence, and how to preserve a crime scene.

The facility has not had any PREA related investigations.

Standard 115.222 Policies to ensure referrals of allegations for investigations

D Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

Policy and Procedures Manual Policy # 12-009 Subject: PREA Investigations establishes the policy to ensure that all allegations are referred for investigation. This policy reads as follows:

Scope: *Thispolicy is applicable to the governing body, allfacility employees, all residents underfacility supervision, volunteers, contractors, interns, visitors, and to all those individuals and groups that conduct business with or use resources of the company.*

Policy: *Firetree, Ltd. shall ensure that an administrative or criminal investigation is completed/or all allegations of sexual abuse and sexual harassment. Referrals for criminal investigations shall be made to entities with the legal authority to conduct criminal investigations, unless the allegation does not involvepotentially criminal behavior.*

The above policy ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment.

I reviewed the policy in its entirety and found it to be complete.

All staff interviewed understand the impmiance of ensuring all allegations are refeffed for investigation. They also understand the procedure of contacting the facility director who would in turn the Bureau of Prisons.

The facility has not had any investigations related to sexual abuse or sexual harassment within the facility. They responded to one incident that had occUffed in the community, but was reported to the facility.

Standard 115.231 Employee training

D Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

The agency trains all of its employees on the aspects of the Prison Rape Elimination Act, as well as their overall response to incidents in the facility. The training is conducted by the Facility Director or the PREA Coordinator.

I reviewed the training syllabus utilized by the facility to train all employees. I found that the training covers all aspects of this standard. The training is tailored to the gender population of the facility.

Inaddition to the training provided by the agency all of the staff attend the PA DOC training academy where they receive the training again.

During the onsite portion of the audit I viewed all of the training records for the staff, I found them to be complete and up to date. During the staff interviews the staff were asked about overall training content, they all confirmed that the training covered the aspects of the standard. They also informed me that with this training they are now equipped to respond to an incident of sexual abuse or sexual harassment.

The facility provides refresher training every two years, this was confirmed with the Facility Director and PREA Coordinator.

Standard 115.232 Volunteer and contractor training

D Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires coffective action)

EVIDENCE OF COMPLIANCE:

The agency provides training to all volunteers and contractors who have contact with residents. They arn trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures. This level of training is based upon their contact with the residents. The agency utilizes the PADOC training information for all volunteers and contractors. These training documents were adapted from the information provided in the PA Bureau of Community Corrections policies. I had the opportunity to review the training provided, the training covered their responsibilities uuder the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures. During this training they are also provided a copy of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.

I reviewed the training records and found them to be complete. No volunteers were available during the audit.

Standard 115.233 Resident education

D Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

Policy and Procedures Manual Policy # 12-011 Subject: Resident Education establishes the procedures for training residents on the agencies zero tolerance policy and repmting procedures. This policy reads as follows:

Scope: Thispolicy is applicable to allfacility residents including transfers and new receptions.

Policy: Every resident, including transfers and new receptions, will receive information regarding Firetee, Ltd. 's zero tolerance policy on sexual abuse and sexual harassment, how to report incidents and suspicions of sexual abuse or sexual harassment, and to befree from retaliation for reporting such incidents, and regarding policy and procedures for responding to such incidents.

Procedures:

1. *Each Resident, including transfers and new intakes, will receive a copy of the PREA Brochure in English or Spanish immediately upon arrival at thefacility. The resident shall sign the Resident PREA Brochure Receipt. Any staff member who received Pfil"'A basic training may provide the PREA Brochure to residents. Questions that cannot be answered by the staff member should be referred to the PCM orfacility director!designee.*

2. *Thefacility director!designee shall ensure resident orientation and education isprovided informats accessible to all residents including those who are limited English proficient, deqf, visually impaired, or otherwise disabled as well as to residents who have limited reading sldlls.*

3. *A dai(y communication of the Zero Tolerance Fact Sheet is communicated to residents.*

4. *More thorough resident education will beprovided by a trained counselor!designee within 14 days of reception or transfer, using:*

a. *The Sexual Abuse/Sexual Harassment Education Program facilitator training guide! PowerPoint and*
b. *The PREA Resource Center resident education video and facilitator's guide.*

5. *The curriculum may beprovided to residents individually or in groups. Security staff may not conduct the resident education program. The PREA Compliance Manage (PCM) shall ensure the counselor orpresenter received PREA basis training and is able to answer questions specific to thefacility's response to a PREA report.*

6. *The counselor orpresenter must bepresent at all times tofacilitate discussion on thepresentation/ video and to answer questions and meet individually with any of the residents, if they request, to discuss issues related to PREA.*

7. *Documentation that sexual abuse and sexual harassment training has occurred, during orientation, shall be recorded on the PREA Resident Training and Understanding Verificationform and maintained in the resident's file.*

Any resident being received at the facility is given the information relative to the agency's zero-tolerance policy regarding sexual abuse and sexual harassment mid how to report incidents or suspicions of sexual abuse or sexual harassment. I reviewed the signoff sheets for the resident education and found that the residents are receiving the education and information. This was also confirmed during the random resident interviews, all residents confirmed they received the initial information and more in depth education. I further interviewed several counselors who provide the training, they informed me that the initial information is being provided upon admission to the facility, and more in depth training is occurring within the two weeks.

I reviewed the documentation that is provided to the residents and found that it meets the requirements of this standard.

The facility is also posted in all common areas as well as the living quarters with the information on PREA.

Standard 115.234 Specialized training: Investigations

[gj Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

The PA DOC residents fall under thefollowing policy for investigations:

BCC-ADM 008, Section 2- Prevention and Training addresses educationfor investigators. Thepolicy reads as follows:
Any employee who conducts sexual abuse investigations shall receive specialized training specific to Corifinement settings through the Department or other approved source. This training shall include techniquesfor interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in corifinement

settings, and the criteria and evidence required to substantiate a casefor administrative actions orprosecution referral. (§ll 5.234[a}[b}[d])

Staff may complete training offered by the Department or by another source whose curriculum complies with the Federal PREA Standards.

Each individual who receives any type of training (basic, ongoing, or specialized) shall complete and sign the PREA Training Receipt for Department and Contract Employees, Volunteers, and Interns (Attachment 2-H). (§115.231[d}) (§115.232[c]) (§115.234[c])

Any incident would be investigated by the Bureau of Prisons Office of Inspector General, Internal Affairs, these investigators are tasked with investigating the administrative investigation. Ifthe investigation is criminal the Syracuse Police Department would conduct the criminal investigation. It was confirmed with the BOP Residential Re-entry Manager that all investigators have received the needed training.

In continuing their efforts to commit to the Prison Rape Elimination Act Firetree, LTD. has trained George Bishop, Corporate Counsel, as the agency investigator.

The facility has not had any investigations related to sexual abuse or sexual harassment, within the facility.

Standard 115.235 Specialized training: Medical and mental health care

D Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

This standard is not applicable to the facility, they do not have medical nor mental health staff.

Standard 115.241 Screening for risk of victimization and abusiveness

181 Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

Policy and Procedures Manual Policy # 12-014 Subject: PREA Risk Screening and Use of Screening Information establishes the policy for screening residents and the use of this screening information. This policy reads as follows:

Scope: Thispolicy is applicable to the governing body, allfacility employees, and all residents under facility supervision, and to all those individuals and groups that conduct business with or use resources of thefacility.

Policy: Every resident shall be assessedfor risk of being sexually abused by other residents or sexually abusive toward other residents. Results of the assessments are used to make individualized determinations regarding housing, sleeping room, and program assignments with the goal of keeping residents safe.

Procedures:

I. Every resident shall be assessed for risk of being sexually abused by other residents or sexually abusive towards other residents:

a. Within 72 hours of admission into the program, including transfers;
b. Between 20-30 days after initial reception into the program
c. When the resident is involved (victim or abuser) in an incident/ allegation of sexual harassment and/ or sexual abuse
d. When warranted due to referral, request or receipt of additional iriformation that bears on the resident's risk of sexual victimization of abusiveness.

2. The risk assessments shall be conducted utilizing the PREA Risk Assessment Tool otherwise known as the PRAT. The tool will be an objective instrument that shall consider, at a minimum, thefollowing criteria to assess residentsfor risk of sexual victimization:

a. Whether the resident has a mental, physical, or developmental disability;
b. The age of the resident;
c. The physical build of the resident
d. Whether the resident has previously been incarcerated
e. Whether the resident's criminal history is exclusively nonviolent
f Whether the resident has prior convictions for sex offenses against a child or adult;
g. Whether the resident is or ispreviously to be gay, lesbian, bisexual, transgender, intersex, or gender non-conforming
h. Whether the resident has previously experienced sexual victimization
i. The resident's own perception of vulnerability, and
j. Whether the resident is detained solely for immigration purposes

3. The initial assessment (within 72 hours of admission) shall be conducted by a trained counselor and consider prior acts of abuse, prior convictions for violent offenses, and history of prior institutional violence of sexual abuse, as known to thefacility, in order to assess residents for the risk of being sexually abusive.

4. Follow-up assessments, including the 20 – 30 day assessment shall be conducted by the trained counselor assigned to the resident.

5. Residents shall not be disciplined for refusing to answer, orfor not disclosing complete information in response to questions regarding prior victimization, disabilities, and their perception of vulnerability or their sexual orientation.

The faciliiy uses a comprehensive screening tool to screen incoming residents. The screening tool was developed by the Pem1Sylvania Department of Corrections and identifies all of the specific questions enumerated in the standard.

During the resident interviews specific questions were asked relevant to the screening tool and questions asked. All residents related that they were asked the questions, this took place as soon as they arrived at the facility.

I was able to view several completed screening tools and found them to be accurate and complete.

During the staff interviews I confirmed that the screening tool is completed within 72 hrs. of arrival. I also confirmed that any new information received during incarceration is taken into consideration for risk of abusiveness or sexual victimization. I further confinned that a second screening tool is being conducted within the 30 day timeframe indicated in the standard. I was also able to confirm this by reviewing the tracking form, all dates for the screening tools were within the initial 72 hr. timeframe and secondary screening within the 30 day timeframe.

All of the information is kept in a secure file, and only accessible to those administrators who would need the infonnation.

Standard 115.242 Use of screening information

Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

Policy and Procedures Manual Policy # 12-014 Subject: PREA Risk Screening and Use of Screening Information establishes the policy for screening residents and the use of this screening information. This policy reads as follows:

6. The information received through the administration of the PRAT shall be used to make individualized determinations regarding assignments to housing!sleeping rooms, work, education, and program assignment with the goal of keeping residents safe and keeping separate those residents at high-risk of being sexually victimized from those at high-risk of being sexually abusive.

7. Jf a resident refases to answer the PRAT questions, the staff member will emphasize the importance of answering the questions honestly to assist in the proper placement and document any refusals.

8. The answers to the PRAT should be stored in a secure location with access restricted to administrative personnel only. Information and scores shall only be made available to select staff to aid in housing, bed, and program assignment with the goal to keep separate those residents at high-risk of being sexually victimized from those residents at high risk of being sexually abusive, and shall never be shared with the residents.

9. An agency specific PRAT assessment tool that meets PREA standards may be used. This tool must be made availablefor review upon request by the Federal Bureau of Prisons (BOP), or Department qf Corrections (DOC)/ Pennsylvania Board of Probation and Parole (PBPP). Assessments for DOC referrals may also be conducted using the electronic PRAT in WEBTAS, as available.

10. A tracking system shall be established to accurately record and track thefollowing information, resident name and number, admission date, assessment and re-assessment deadline and completion dates, yes or no high-risk categorization resultsfor victim, abuser, and LGBTI (Lesbian, Gay, Bisexual, Transgender, and Intersex), and sleeping room assignments.

11. Firetree, Ltd. shall consider on a case-by-case basis the assignment of a transgender or intersex resident into thefacility in terms of ability to ensure resident's health and safety, and whether theplacement would present management or security problems.

12. For DOC (LGBTI) residents, placement discussion shall occur between thefacility and designated DOC staff These discussions shall focus on sleeping quarters, use of bathroom/shower facilities, facility-based activities, community-based resources, and general questions or clarification. The PREA Compliance Manager (PCM) shall seek anyfurther clarification with the Regional Director/ designee, as necessary.

13. For DOC (LGBTI) residents, factors used to determine placement as well as placement outcome shall be documented on the Transgenderl lntersex Resident Placement Notes Attachment 2-F report. All follow-up reviews, determinations, discussion, and assignments specifically related to LGBTI policy requirements shall be documented on this report. This report is maintained in the resident'sfile with access restricted to the assigned counselor, counselor supervisor, and PREA compliance manager. This report shall be provided to the Regional Director upon resident dischargefrom theprogram.

14. Equivalent documentation shall be established and maintained for non-DOC (LGBTJ) residents.

15. Uponplacement the PCM shall meet with the resident to discuss placement, answer any questions, and address any concerns.

16. In cases where the resident's potential status as transgender or intersex is revealed after placement, the PCM shall be notified without delay. The PCM shall meet with the resident to discuss thepotential change status and notification made the Regional Director or other appropriate referral source entity with the proper confidentiality consent completed.

17. A transgender or intersex resident's own views with respect to sqfety shall be given serious consideration. The referral source shall be notified of these concerns as soon as possible.

18. I'ransgender and intersex residents shall be given the opportunity to shower separately from other residents.

19. Changes in sleeping quarters, bathroom/ shower facilities, or any other changes that impact the resident's stability must be reported to the Regional Director, or other applicable referral source designee.

20. Placement and programming assignments/or each transgender or intersex resident shall be reassessed, by the PCM, in consultation withfacility staff that regularly interacts with the resident, every six months to review any threats to safety experienced by the resident.

21. LBGTI residents shall not be mandatorily placed in dedicated facilities, units, or wings solely on the basis of such identification or status, 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 such residents. Residents may, however, volunteer to be housed in such unit if it exists. Thefacility utilizes the information from the screening tool to keep separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive. This is done on a case by case basis, and the decisions are madefrom all information on hand at that time.

During the interviews with the random staff the assignment of resident housing was discussed. All of the interviewees related that they constantly monitor activities of the residents to ensure the safety of any resident who is at high risk for victimization. The staff understood the use of the screening tool information to ensure the health and safety of transgender or intersex imnates.

At the time of the audit they did not have any residents identified as transgender, or intersex.

The information in the screening tool is not available to all staff.

Standard 115.251 Resident reporting

- O Exceeds Standard (substantially exceeds requirement of standard)
- 181 Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- O Does Not Meet Standard (requires c01Tective action)

EVIDENCE OF COMPLIANCE:

Policy and Procedures Manual Policy # 12-013 Subject: Resident reporting establishes resident reporting procedures. This policy reads as follows:

Scope: Thispolicy is applicable to all residents underfacility supervision, and all Firetree, Ltd. employees.

Policy: Firetree, Ltd. has established procedures allowingfor multiple waysfor residents and third parties to report sexual abuse or sexual harassment acts. Procedures shall also be established for stqff toprivately report sexual abuse and sexual harassment of residents.
Procedures:

Reporting:

1. *Residents may privately report sexual abuse, sexual harassment, retaliation by other residents or stafjfor reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. Reports may be made verbally, in writing, anonymously, and from third parties such asfamily andfriends to:*

a. Any staff member;

b. The PREA Compliance Manager (PCM)/facility director

c. BCI/ PREA Coordinator (for DOC residents) at

BCI/ PREA Coordinator
l800 Elmerton Avenue
Harrisburg, PA 17110

d. www.tipsubmit.com

e. VictimAssistance resource specific toprogram location

f National Sexual Assault Telephone Hotline 800-656-HOPE

g. As a last resort use 911

2. *Employees shall accept reports made verbally, in writing, anonymously, and from third parties, document any verbal on a DC-121, Part 3-BCC (for DOC residents) or appropriate significant !unusual incident report applicable to the resident's referral/funding source no later than end of shift, and immediately notifY thefacility director!designee.*

3. *rr a residentfiles a grievance related to sexual abuse, thefacility director/ designee shall immediately reject the grievance and implement investigation according to PREA investigation policy 12-009. The resident will be notified of this action. This will be considered an exhaustion of administrative remedies.*

Anonymous Reporting:

1. *Anyone may make an anonymous report of an allegation of sexual abuse or sexual harassment on behalf of the resident via the above listed reporting avenues :*

2. *This address and website listed for the BCJ/ PREA Coordinator above are not part of the Department of Corrections or Firetree, Ltd. and the BCJ/ PREA Coordinator is able to receive and immediately forward reports of sexual abuse and sexual harassment to Firetree, Ltd. The reporter may remain anonymous upon request.*

3. *The reporting avenues may be used by anyone including employees, residents, friends, family, volunteers, visitors, interns, contractors, vendors, and the general public.*

The facility provides several internal ways of privately reporting sexual abuse and sexual harassment, retaliation by other residents or staff. The staff and residents interviewed were all aware of internal reporting, such as reporting directly to a staff member or in written form through channels. Everyone was also aware of the NYS Crime Stoppers, Vera House hotline and the national reporting line all which can be used for anonymously reporting incidents.

All of these reports including those that need immediate attention, are filtered to the Facility Director.

During the resident interviews I asked about the level of comfort they had in reporting directly to a staff member, all of the interviewees related that they felt comfortable reporting to a staff member. They also understood how to report an incident.

The resident reporting procedures and information are posted throughout the facility.

I was able to view the signage with the PREA information in all of the housing areas, corridors, and common areas.

Standard 115.252 Exhaustion of administrative remedies

D Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

The agency does not accept any written grievance pertaining to sexual assault incidents.

Standard 115.253 Resident access to outside confidential support services

D Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

Policy and Procedures Manual Policy # 12-008 Subject: Access to Emergency Medical & Mental Health Services, Forensic Medical Examinations, and Victim Advocate Services, and Follow-up Services. This policy reads as follows:

Scope: Thispolicy is applicable to the governing body, allfacility employees, all residents underfacility supervision, and to all those individuals and groups that conduct business with or use resources of thefacility.
Policy: Resident victims f sexual abuse shall 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. Victims of sexual abuse shall be offered access to aforensic medical examination, and medical and mental health sexual abusefollow-up services.

Procedures:

17. *Upon learning of an allegation that a resident was sexually abused, thefirst staff member to respond shall take immediate and appropriate steps to ensure the resident's safety and actions to maximize the potential for obtaining usable physical evidence in accordance with Staff First Responder Duties Policy 12-018.*

18. *The PREA Compliance Manager (PCM) shall coordinate medical services related to sexual abusefor theirfacility and where possible, utilize a hospital that employs a Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE).*

19. *Letters of agreement shall be maintained for forensic medical examinations by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs).*

20. *Staff shall not take any photographs when a sexual abuse allegation is made. The collection of any*

photographic evidence must be conducted by the outside medical professional or law enforcement.

21. On-site medical staff shall not conductforensic medical exams of residents.

22. Jn orderfor aforensic medical examination to beperformed, the report must be made within 96 hours of the abuse happening. Theforensic examination will occur at the hospital in an attempt to try to collect anypossible evidence that may bepresent. Because qf this, there are several things that one needs to keep in mind.

- *Even though one may want to clean up after the abuse, it is important to see supervisory staff BEFORE one showers, washes, drinks, eats, smokes, changes clothing, or uses the bathroom.*
- *Hospital medical staff will examine the residentfor injuries, which may or may not be readily apparent to the resident.*

23. Forensic medical examinations shall be offered to all victims of sexual abuse, withoutfinancial cost, where evidentiary and medically appropriate. Nofinancial liability is assumed by Firetree, Ltd. as sexual abuseforensic examinations arefitnded in accordance with CFR Title 28, Chapter 1Part 90 Subpart B, Section 90.14.

24. The PREA Compliance Manager shall coordinate victim services related to theirfacility.

25. The PCM shall work with the Pennsylvania Coalition against Rape (PCAR) approved local rape crisis center to establish a Rape Crisis Letter of Agreement for victim advocate and emotional supportive services. These services shall be offered to all sexual abuse victims.

26. Notification about available services (attachment 4-C) shall beposted in thefacility common areas accessed by residents. Theposting shall include the addressfor local services, and phone numbers, including toll-free hotline numbers where available, with written consent of the organization providing the services. Thefacility shall enable reasonable communication between residents and these organizations in as confidential a manner as possible. Thefacility shall not monitor these communications.

27. Jf the victim refuses to go to the hospitalfor forensic examination, the rape crisis center will be asked to help in the matter. Normally with client consent, a rape crisis victim advocate will meet the client at the hospital in theprovision of victim advocate services.

28. The PREA Compliance Manager (PCM) or designee will accompany the resident during transport to a hospital. The PCM does not necessarily have to travel in the ambulance with the victim, however at a minimum should meet the victim at the hospital. Thepurpose qf the PCM presence is toprovide emotional support to the victim by sitting with the victim at the hospital and to ensure theproper coordination with the victim advocate service. The PCM shall not bepresent in theforensic examination room. It ispermissible upon requestfrom the victim, to allow the victim 'sfamily to provide the transport to the hospital.

29. With the resident's consent, the hmpital staff can also test and provide treatment/or sexually transmitted infections, possible exposure to diseases such as HIV and Hepatitis, and gather any physical evidence of abuse.

30. Females may be testedfor pregnancy at the hospital when appropriate.

31. *Residents who are victim of an abuse by staff or other resident(s) may seek counseling and/or advice from a psychologist or chaplain. Crisis counseling, coping skills, suicide prevention and mental health counseling are to be available to the resident. Most individuals need help to recoverfrom the emotional effects of sexual abuse. Rape crisis victim advocates serve to accompany and strpport the victim through theforensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals.*

32. *To the extent Firetree, Ltd. itself is not responsiblefor investigating allegations of sexual abuse it shall request that the investigating agency follow the requirements setforth in thispolicy. This request shall be documented.*

Follow-up Services:

6. *The PCM shall coordinate medical and mental health evaluations and, as appropriate, treatmentfor all residents who have been victimized by sexual abuse in any prison, jail, lockup, juvenile facility, or community confinement facility. This includesfollow-up services, treatment plans, and referrals for continued carefollowing their releasefrom thefacility.*

7. *The PCM shall coordinate medical services and referrals for treatment in the community, in accordance with professionally accepted standards, to include: offered pregnancy testsfor resident victims of sexually abusive vaginal penetration during incarceration, timely and comprehensive information about and access to emergency contraception; lawfitl pregnancy-related services (if pregnancy results from sexually abusive vaginal penetration); Sexually Transmitted Infections (ST!) testing and follow-up treatment.*

8. *Medical and mental health referrals shall occur to locations providing servicers consistent with the community level of care.*

9. *Thefacility shall attempt to have a mental health evaluation conducted of all known resident-on-resident abusers within 60 days of learning such abuse history and offer treatment when deemed appropriate by mental health practitioners.*

I 0. *Services shall beprovided withoutfinancial cost to the victim regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. This financial obligation ends when the resident is released from thefacility.*

The agency utilizes Vera House Rape Crisis Center for outside victim advocacy, and has entered into a MOU with them. I reviewed the MOU and found this to be in effect, the MOU is dated April 28, 2015.

It should be noted that the facility had no incidents of sexual abuse where these services were utilized.

Standard 115.254 Third-party reporting

D Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

The agency has the following posted on their website:

Firetree, Ltd. maintains zero tolerance towards allforms of institutional and community-based sexual abuse and harassment. Measures have been developed and implemented in order toprevent, detect, and respond to sexual abuse and sexual harassment conduct. Thispolicy is applicable to the governing body, allfacility employees, all residents underfacility supervision, volunteers, contractors, interns, visitors, and to all those individuals and groups that conduct business with or use resources of the company. Firetree, Ltd. 's complete Zero Tolerance policy can be found here. Zero tolerance audit results can be obtained by contacting:

Employees, clients and clients' families may submit reports anonymously to:

Firetree, Ltd.
PREA Coordinator
800 W 4th St.
Williamsport, PA 17701
Or email to: prea@Firetree.com

In Pennsylvania, reports can be submitted directly to:

BCIIPREA Reporting
1800 Elmerton Ave.
Harrisburg, PA 17110

I viewed the third party reporting information posted inthe main area of the facility for visitors.

Standard 115.261 Staff and agency reporting duties

D Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

Policy and Procedures Manual Policy # 12-015 Subject: Staff and Agency Reporting Duties establishes the reporting duties of both staff and the agency. This policy reads as follows:

Scope: Thispolicy is applicable to the governing body, allfacility employees, all residents, volunteers, contractors, interns, visitors, and to all those individuals and groups that conduct business with or use resources of the company.

Policy: Firetree, Ltd. requires all staff including contracted medical practitioners to report any knowledge, suspicion, or information received regarding sexual abuse or sexual harassment in accordance with procedures outlined below.

Procedures:

Staff Reporting:

4. *All staff shall provide an immediate verbal report to thefacility director/ designee of any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in anyfacility (whether or not it ispart of Firetree, Ltd.); retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. This information shall be documented on a DC-121, Part 3-BCC (DOC), or equivalent rferral/ funding source significant/ unusual incident report.*

5. *Apart from the reporting to designated supervisors or officials, staff shall not reveal any information related to a sexual abuse report to anyone except those specified in thispolicy manual to make treatment, investigation, or other security and management decisions.*

6. *Unless otherwise precluded byfederal, state, or local law, medical and mental health practitioners shall be required to report sexual abuse, pursuant to Procedure Step ! listed above, and to inform residents of thepractitioner's duty to report the limitations of confidentiality at the initiation of services.*

7. *If the alleged victim is under the age of 18, or considered a vulnerable adult under a state or local "Vulnerable Persons" statute, thefacility shall report the allegation to the designated state or local services agency under applicable mandatory reporting laws.*

8. *Thefacility shall report all allegations of sexual abuse and sexual harassment, including third party and anonymous reports, to thefacility's designated investigators. Upon learning of an allegation of sexual abuse or sexual harassment, thefacility director! designee shall:*

   a. Ensure the safety of the victim; and
   b. Verbally notify appropriate reporting entity and document the allegation in accordance with Policy 12-009 PREA Investigations.

When I interviewed the random staff I was impressed with the answers related to staff reporting. All of the staff understood the importance of reporting, what their duties were, and how to effectively report this information. The staff also understood the internal reporting system as well as the external reporting avenues. They all understood the importance of keeping the information reported to them private as well as all applicable mandatory reporting laws.

The facility has not had any investigations related to sexual abuse or sexual harassment, within the facility.

Standard 115.262 Agency protection duties

D Exceeds Standard (substantially exceeds requirement of standard)

181 Meets Standard (substantial compliance; complies in all material ways witb tbe standmd for the relevant review period)

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

Policy and Procedures Manual Policy # 12-016 Subject: Protection of Resident Duties establishes the protection of residents. This policy reads as follows:

Scope: Thispolicy is applicable to the allfacility employees, all residents, volunteers, contractors, interns, visitors, and to all those individuals and groups that conduct business with or use resources of the company.

Policy: When the Firetree, Ltd. program learns that a resident is subject to a substantial risk of imminent sexual abuse, it shall take immediate action toprotect the resident.

Procedures:

9. *Thefacility director! designee shall be immediately contacted and notified when it is learned that a resident is subject to a substantial risk of imminent sexual abuse.*

10. *Thefacility director! designee, in consultation with the governing body and appropriate referral source personnel, shall assess and implement appropriate protective measures without reasonable delay. Measures include, but are not limited to resident transfer, resident sleeping room reassignment, increased surveillance, etc.*

All of tbe staff interviewed understood their duties to protect a resident, tbey all responded in the same manner, they would act immediately. The facility has deemed the monitors office, as the safe area for a resident. The staff also recognized the impmiance of separating tbe alleged offender from further interaction with any otber residents, they all related tbat tbey would have the alleged offender under constant supervision.

Standard 115.263 Reporting to other confinement facilities

D Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

Policy and Procedures Manual Policy # 12-017 Subject: Reporting to Other Confinement Facilities establishes the procedures to report incidents to otber confinement facilities. This policy reads as follows:

Scope: Thispolicy is applicable to the governing body and allfacility employees.

Policy: Notification andfollow-up contact with other confinement facilities shall occur in order to ensure first responder duties, and investigator processes are initiated when sexual abuse or sexual harassment allegations reported at one facility are alleged to have occurred at another facility.

Procedures:
Facility Director!designee Responsibilities

1. *Upon learning of an allegation of sexual abuse or sexual harassment, including third-party and anonymous reports, the Facility Director!designee shall:*
    a. *Ensure the safety of the victim*
    b. *Verbally notify the DOC Operations Center (for DOC residents), Federal Community Corrections Manager, CCM (forfederal residents), and State Police for sexual abuse incidents/ allegations, as appropriate, for action and investigation in accordance with procedures delineated in Policy 12-009*
    c. *Ensure first responder duties are completed in accordance with Staff First Responder Duties for every incident! allegation of sexual abuse; and*
    d. *Document the allegations on a DC-12I , Part 3-BCC, or other appropriate reporting document*

Reports Received about Other Confinement Facilities Where the Alleged Abuse Occurred

1. *Upon receiving an allegation that a resident was sexually abused while confined at another facility , the Facility Director!designee shall document the receipt of the allegation on the appropriate reporting form (DC-21I ,Part 3-BCC, Incident Report, etc.).*

2. *For non-DOC and non.federal residents, the Facility Director! designee receiving the allegation will notify the head of thefacility or appropriate office of the agency where the alleged abuse occurred, with consent when appropriate.*

3. *The BCC Operations Center (for DOC residents) or the Federal BOP CCM office (forfederal residents), will make initial contact with the affected facility and the reporting Facility Director/ designee shall make follow-up contact with the affected Facility Manager within 72 hours of report.*

4. *The affected facility will beprovided a copy of the confidential report and contact information for any follow-up questions.*

Reports Received from Other Confinement Facilities regarding Alleged Abuse that Occurred in the Firetree, Ltd. Facility

I I . Upon receiving an allegation of sexual abuse from another facility (Community Corrections Center [CCC}, Residential Re-entry Center [RRC}, Community Contract Facility [CCI'], Federal Correctional Institution [FCI], State Correctional Institution [SCI], County Jail, etc.) about an allegation of sexual abuse or sexual harassment, that is alleged to have occurred in the Fire tree, Ltd. facility that is being notified of the allegation, the Facility Director, or designee shall document the receipt of the allegation on the appropriate reporting form (DC-121, Part 3-BCC, Incident Report; etc.), and verbal notification shall occur without delay to the applicable resident's appropriate referral/ fimding entity.

I 2. The BCC Operations Center (for DOC resident;,), or the CCM (forfederal residents) take actions as outlined in the First Responder policy and the Investigation policy 12-009.

Reports Received about Incident!Allegations in the Community

I . Upon occasion, a resident may report that they have been the victim of sexual abuse, sexual assault, rape, etc. in the community.

2. *The Facility Director/ designee shall ensure the resident's sefety and take actions as outlined in First Responder policy and the Investigation policy 12-009.*

During my interview with the Facility Director he understood his responsibilities under this policy. He related that they would take any innnediate steps needed to ensure the preservation of evidence and he would contact the facility where the incident occurred personally.

The facility has not had any incidents where the Facility Director needed to contact another facility.

Standard 115.264 Staff first responder duties

D Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

Policy and Procedures Manual Policy # 12-018 Subject: Staff First Responder Duties establishes the duties of first responders. This policy reads as follows:

Scope: Thispolicy is applicable to the governing hody and allfacility employees.

Policy: Upon learning f an allegation that a resident was sexually abused, thefirst staff member to respond shall take immediate and appropriate steps to ensure the resident's safety and actions to maximize the potential for obtaining usable physical evidence.
Procedures:

First Responder Duties:

2. *Upon learning of an allegation of sexual abuse, thefirst staff to respond shall take immediate action and:*
   a. Call "911" if a physical and! or sexual assault is inprogress;
   b. As soon as safely possible, separate the alleged victim and alleged abuser;
   c. Escort the victim to a safe location away from others;
   d. Notify the Facility Director/ designee;
   e. Contact the DOC Operations Center (for DOC residents), or the CCM office (forfederal residents) and follow all direction provided to include preserving and protecting anypossible crime scene until appropriate steps can be taken to collect evidence; and
   f Complete the First Responder Checklist (Attachment 4-D) and a DC-121, Part 3- BCC for DOC residents, and equivalent checklist procedures and reporting forms for non-DOC residents; and
   g. *Secure and protect the potential crime scene, until physical evidence can be collected by law enforcement and/ or an outside medical professional. If the abuse occurred within a time period that still allowsfor the collection of physical evidence (96 hours), request shall be made to the alleged victim that no actions take place that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating.*
   h. If the abuse occurred within a timeperiod that still allowsfor 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.

All staff interviewed understood their responsibilities when responding to an incident. They all related that they would act immediately to ensure the safety of the resident, as well as the other residents, and make the necessary notifications. They all related that they would utilize the designated safe area in the facility to place the victim and have the alleged offender under direct supervision.

The facility has not had any incidents where these procedures were utilized.

Standard 115.265 Coordinated response

D Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

Overall policy establishes the coordinated response by Syracuse Pavilion. This response includes the facility staff, local police, Bureau of Prisons, and Firetree, LTD investigator.

All of the staff interviewed understood the impmtance of a coordinated response to an incident, and understood who needed to be contacted.

The facility has not had any incidents related to sexual abuse or sexual harassment.

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

D Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

The agency has not entered into any agreements that would limit their ability to protect residents from contact with abusers.

Standard 115.267 Agency protection against retaliation

D Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

Policy and Procedures Manual Policy # 12-021 Subject: Protection Against Retaliation establishes the agencies protection duties. This policy reads as follows:

Scope: Thispolicy is applicable to the governing body, and allfacility employees and residents.

Policy: Firetree, Ltd. programs shall protect all residents and staff who report sexual abuse or sexual harassment or who cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff Actions may include:

I) Administrative or criminal investigation
2) Housing changes or transfers for resident victims or abusers
3) Removal of alleged abusersfrom contact with victims; and/or
4) Emotional support services for residents or staff

Procedures:

I. For at least 90 days, and longer if deemed necessary, following a report of sexual abuse, the PREA Compliance Manager (PCM) shall monitor the conduct and treatment of
   a) Residents who reported sexual abuse;
   b) Residents who were reported to have suffered sexual abuse;
   c) Staff who reported sexual abuse; and
   d) Any other individual who cooperates with a sexual abuse or sexual harassment investigation and expresses afear of retaliation.
2. The PCM shall monitor these individuals to see !f there are changes that may suggest retaliation by residents or staff by:
   a) Reviewing the resident's infraction reports, program reports, and housing/ room assignment;
   b) Reviewing negative stqff peiformance reviews or staff reassignment;
   c) Negative interactions with other staff or other residents;
   d) Meeting with the resident bi-weekly to discuss their progress; and
   e) Document on the Retaliation Monitoring {Attachment 5-A)form.
3. When retaliation is suspected, the PCM shall immediately contact the COO and the Regional Director (for DOC residents) or the Community Corrections Manager, CCM (forfederal residents) so that appropriate steps may be taken toprotect the individual and remedy any such retaliation.

The Facility Director would be tasked with monitoring any reported retaliation. During his interview he understood his role in monitoring retaliation.

There have been no PREA incidents that have required investigations for retaliation.

Standard 115.271 Criminal and administrative agency investigations

D Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

Policy and Procedures Manual Policy # 12-009 Subject: PREA hwestigations establishes the agencies investigation policies. This policy reads as follows:

Subject: PREA Investigations

Scope: Thispolicy is applicable to the governing body, allfacility employees, all residents underfacility supervision, volunteers, contractors, interns, visitors, and to all those individuals and groups that conduct business with or use resources of the company.

Policy: Firetree, Ltd. shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. Referrals for criminal investigations shall be made to entities with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior.

Procedures:

1. *All reported incidents/ allegations of sexual abuse and/ or sexual harassment of residents shall be investigated promptly, thoroughly, and objectively, including third-party and anonymous reports.*

2. *Administrative investigations shall include an effort to determine whether staff actions orfailures to act contributed to the abuse; and shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings.*

3. *Criminal investigator actions and responsibilities include:*
    a) *Investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims; suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator.*
    b) *Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution.*
    c) *When the quality of evidence appears to support criminal prosecution, compelled interviews occur only qfter consulting the prosecutors as to whether compelled interviews may be an obstaclefor subsequent criminal prosecution.*
    d) *The credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person's status as resident or staff. No agency shall require a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a conditionfor proceeding with the investigation of such allegation.*
    e) *Criminal investigations shall be documented in a written report that contains a thorough description ofphysical, testimonial, and documentary evidence and attaches copies of all documentary evidence whenfeasible.*

4. *Firetree, Ltd. shall retain all obtained written administrative and criminal investigative reports as long as the abuser is incarcerated or employed by theprogram, plus five years.*

5. *The departure of the alleged abuser or victimfrom the employment or control of the Firetree, Ltd. program or agency shall notprovide a basisfor terminating an investigation.*

6. *When outside agencies investigate sexual abuse, thefacility shall cooperate with outside investigators and shall endeavor to remain informed of theprogress of the investigation.*

7. *For residents under thejurisdiction of the PA Department of Corrections, the program will immediately notify the Bureau of Community Corrections Operations Center of allegations of sexual abuse and sexual harassment. The BCC Operations Center will in turn notify the Pennsylvania State Police of allegations of sexual abuse and sexual harassment, unless the allegation does not involve potentially criminal behavior, and will assign a BCC investigator to track the progress. Subsequent to the criminal investigation, an administrative investigation shall be conducted by a BCC assigned investigator to determine internal discipline and contract violations.*

8. *For residents under thejurisdiction of the PA Department of Corrections, sexual harassment allegations that do not potentially involve criminal behavior shall be administratively investigated by a BCC investigator assigned by the BCC Operations Center. Firetree, Ltd. staff shall not conduct administrative investigations that involve a DOC/ PBPP resident.*

9. *An administrative investigation shall be assigned by the BCC for every incident/ allegation of sexual abuse and! or sexual harassment and be reported to the Department's Office of Special Investigations and Intelligence (OSJI). Completed investigations shall beforwarded to the BCC Major/ designeefor revie w, processing, andfinal approval by the Bureau Director/ designee. The completed investigation packet (including supporting documentation) shall beforwarded to the Department PREA Coordinator and OSJI by the due date assigned by the OSJl OSI!shall provide notification to the Bureau Director/ designee regarding case review. Upon receipt of this notification, the Bureau Director/ designee shall direct and document necessary administrative action.*

10. *For residents not under thejurisdiction of the PA Department of Corrections, sexual harassment allegations that do not potentially involve criminal behavior shall be administratively investigated by thefacility director or designee, or in the case of Syracuse Pavilion or Capitol Pavilion federal residents by Federal Bureau of Prisons personnel or thefacility director at the discretion of the BOP CCM Thepurpose of the administrative investigation is to determine whether an inappropriate act occurred, whether policy and procedure was properly followed, and whether staff actions orfailures facilitated the act. DOC contracted programs willprovide the DOC with a courtesy notification of the incident and subsequent notification that there has been a disposition. If it is determined during the administrative investigation that the allegation does involve potentially criminal behavior, the administrative investigation is stopped and notification made to the State Police. Administrative sexual abuse investigation is then initiated at the conclusion of the criminal investigation in accordance with Procedure Step 9 below.*

11. *For residents not under thejurisdiction of the PA Department of Corrections, the program will immediately notifY the Pennsylvania State Police (or New York State Police for Syracuse Pavilion), of allegations of sexual abuse and sexual harassment, unless the allegation does not involve potentially criminal behavior. Syracuse Pavilion and Capitol Pavilion for federal residents will additionally notify the BOP Community Corrections Manager (CCM) or designee.*

12. *Confidentiality will be maintained throughout the investigatory process to the extent consistent with adequate investigation and appropriate responsive action.*

13. *An administrative sexual abuse investigation shall be conducted by designated Firetree, Ltd. staff that have received specialized sexual abuse investigator training. This investigation is conducted following the conclusion of the criminal investigation.*

14. *Specialized sexual abuse investigator training shall include techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in coryfinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral.*

15. *Documentation of administrative sexual abuse investigator training shall be maintained in the staff's respective training record files.*

All staff understood their responsibilities in the investigative process.

Any incident would be investigated by the Bureau of Prisons Office of Inspector General, Internal Affairs, these investigators are tasked with investigating the administrative investigation. lfthe investigation is criminal the Syracuse Police Department would conduct the criminal investigation.

The facility has not had any PREA related incidents, within the facility.

Standard 115.272 Evidentiary standard for administrative investigations

D Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

Policy and Procedures Manual Policy # 12-022 Subject: Evidentiary Standards for Administrative Investigations establishes the standard for administrative investigations. This policy reads as follows:

Scope: Thispolicy is applicable to allfacility employees.

Policy: Firetree, Ltd. programs shall impose no standard higher than a preponderance of evidence in determining whether administratively investigated allegations of sexual abuse or sexual harassment are substantiated.

I have reviewed numerous agency investigations on PREA allegations, these investigations had been provided to me during the agency level interviews, and prior contracted facilities audits. I found that the level of preponderance of the evidence has been consistently applied to these investigations.

I confinned during the interview with the agency investigator that he understood the level of evidence applied in an administrative investigation.

Standard 115.273 Reporting to residents

D Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

Policy and Procedures Manual Policy # 12-023 Subject: Reporting to Residents establishes the procedures to report outcome of investigation to residents. This policy reads as follows:

Scope: Thispolicy is applicable to allfacility employees and residents.

Policy: Firetree, Ltd. shall inform any resident who makes an allegation that he or she suffered sexual abuse, in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation. Allegation decisions are defined asfollows:

- *Substantiated - an allegation that was investigated and determined to have occurred*
- *Unsubstantiated – an allegation that was investigated and the investigation produced insufficient evidence to make afinal determination as to whether or not the event occurred.*
- *Unfounded - an allegation that was investigated and determined not to have occurred.*

Procedures:

1. *The PREA Compliance Manager, PCM at the.facility where the resident is housed, shall request the relevant criminal investigation information and relevant administrative investigation information if the administrative investigation was not conducted by the Firetree, Ltd. program, from the investigative agency in order to inform the resident in writing, as to the allegation result. For DOC residents, the BCC PREA investigator will request the relevant information from the investigative agency andforward it to the PCM, who in turn will inform the resident.*

2. *Fallowing a resident's allegation that a staff member has committed sexual abuse against the resident, the PCM shall subsequently iY?form the resident (unless the allegation is determined to be unfounded) when any of thefollowing occur:*
   a) *The staff member is no longer posted within the resident's unit;*
   b) *The staff member is no longer employed at thefacility;*
   c) *The agency learns the staff member has been criminally charged related to sexual abuse or sexual harassment within thefacility; or*
   d) *The agency learns that the staff member has been convicted on a charge related to sexual abuse or sexual harassment within thefacility.*

3. *Following a resident's allegation that he or she has been sexually abused by another resident, the PCM shall subsequently inform the alleged victim whenever:*
   a) *Theprogram learns that the alleged abuser has been criminally charged related to sexual abuse within thefacility; or*
   b) *The program learns that the abuser has been convicted on a charge related to sexual abuse within thefacility.*

4. *These notifications apply to the victim only. Third-party reporters will not be notified of outcomes and! or actions.*

5. *All such notifications or attempted notifications shall be documented via the Resident Notification- PREA (Attachment 8-A)form for DOC residents or similar report/or non-DOC residents. The completed notification forms are placed in the resident's file. DOC resident notifications areforwarded to the DOC PREA Captain/ designee and the Contract Facility Coordinator, CFC.*

6. *Theprogram's obligation to report the results of the investigation or other actions under thispolicy under this standard shall terminate if the resident is released from the agency's custody, except in instances where the resident was transferred to another Firetree, Ltd. program contracted with the DOC.*

The Facility Director understood his obligation under this policy.

The facility has not has any investigations of sexual abuse or sexual harassment, within the facility.

Standard 115.276 Disciplinary sanctions for staff

D Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

Policy and Procedures Manual Policy # 12-024 Subject: Disciplinary Sanctions for Staff establishes the procedures for staff discipline. This policy reads as follows:

Scope: Thispolicy is applicable to allfacility employees.

Policy: Any Firetree, Ltd. employee who engages in,fails to report, or knowingly condones sexual abuse or sexual harassment of a resident shall be subject to appropriate disciplinary or administrative action.

Procedures:

1. *All Firetree, Ltd. employees shall be subject to disciplinary sanctions up to and including termination for violating sexual abuse or sexual harassment policies.*

2. *Termination shall be thepresumptive disciplinary sanction for staff who has engaged in sexual abuse.*

3. *Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) shall be commensurate with the nature and circumstances qf the acts committed, the staff member's disciplinary history, and the sanctions imposedfor comparable offenses by other staff with similar history.*

4. *All activity that is the basis qf terminations or violations of sexual abuse or sexual harassment policies, or*

resignations by staff who would have been terminated if notfor the resignation, shall be reported to law enforcement agencies and relevant licensing bodies, unless the activity was clearly not criminal, and to relevant licensing bodies when not criminal.

5. *Firetree, Ltd. firing practices must comply with the National Prison Rape Elimination Act (PREA) standards.*

The facility has not had any investigations where a staff member was disciplined. This was confirmed by my interview with the Facility Director.

Standard 115.277 Corrective action for contractors and volunteers

D Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

Policy and Procedures Manual Policy # 12-025 Subject: Corrective Action for Contractors, Volunteers, and Interns establishes the procedures for corrective action. This policy reads as follows:

Scope: This policy is applicable to all facility employees.

Policy: Any Firetree, Ltd. contractor, volunteer, or intern who engages in,fails to report, or knowingly condones sexual abuse or sexual harassment f a resident shall be subject to appropriate disciplinary or administrative action.

Procedures:

1. *Any contractor, volunteer, or intern who engages in sexual abuse shall beprohibited from contact with residents and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies.*
2. *The Firetree, Ltd. program shall take appropriate remedial measures and shall consider whether toprohibit further contact with residents, in the case of any other violation ofprogram sexual abuse or sexual harassment policies by a contractor or volunteer.*

The facility has not had any investigations where a contractor or volunteer was involved. This was confirmed by my interview with the Facility Director.

Standard 115.278 Disciplinary sanctions for residents

D Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

Policy and Procedures Manual Policy # 12-026 Subject: Disciplinary Sanctions for Residents establishes the procedures for resident discipline. This policy reads as follows:

Scope: Thispolicy is applicable to the governing body, allfacility employees, residents, and to all those individuals and groups that conduct business with or use resources of thefacility.

Policy: Residents are subject to disciplinary sanctions only pursuant to aformal disciplinary process.

Procedures:

Resident Discipline - General:

3. *Residents shall be subject to disciplinary sanctions pursuant to aformal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse, orfollowing a criminalfinding of guilt for resident-on-resident sexual abuse.*

4. *Sanctions shall be commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposedfor comparable offenses by other residents with similar histories.*

5. *The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed.*

6. *If the allegation of sexual abuse has been substantiated, the resident abuser will be discharged from the facility where the abuse occurred.*

7. *For thepurpose of disciplinary action, a report of sexual abuse made in good faith, based upon a reasonable belief that the alleged conduct occurred, shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.*

8. *Theprogram may discipline a residentfor sexual contact with staff only upon a finding that the staff member did not consent to such contact.*

9. *Firetree, Ltd. program •prohibit all sexual activity between residents and disciplines residentsfor such activity. Theprograms will not deem such activity to constitute sexual abuse if determination is made that the activity is not coerced (meaning it is consensual).*

Disciplinary Sanctions - PBPP (State Parole Residents):

1. *When a PBPP resident is alleged to have committed sexual abuse, the resident shall be separated from the alleged victim. When time and circumstances permit, resident transfer! removalfrom thefacility shall be*

coordinated by the Bureau of Community Corrections (BCC) Investigator and PBPP.

2. *The alleged victim of sexual abuse shall not be removed from thefacility based on the incident, unless they make the request.*

3. *PBPP residents shall be subject tojoint disciplinary sanctions and PBPP administrative actionfollowing an administrative and/ or criminalfinding that the resident engaged in sexual abuse, or consensual sexual acts inside thefacility. The BCC Director! designee will requestfollow-up confirmation of action taken by Parole Supervision staff and attach to the investigative file.*

Disciplinary Sanctions -SIP Residents

1. *When the State Intermediate Punishment (SIP) resident is alleged to have committed sexual abuse, the resident shall be returned to a State Correctional Institution (SCI).*

2. *The alleged victim of sexual abuse shall not be returned to the SCI*

3. *A DOC shall conduct an administrative hearing at the SCI as outlined in DOC Department Policy 8.1.1, Section 19, Community Corrections Centers. The resident shall remain at the SCI pending the outcome of any administrative and/ or criminal investigation. The Bureau of Treatment Services (BTS) Director/ designee shall be notified of the outcome of the hearing and investigation(s).*

4. *SIP residents shall be subject to disciplinary sanctions as outlined in DC-ADM 801, Inmate Discipline, and DOC Department Policy 7.4.1, Alcohol and Other Drug Abuse Treatment Programs, Section 10following an administrative and/ or criminalfinding that the resident engaged in sexual abuse, or Misconduct #19, Engaging in Sexual Acts with Others, or Sodomy.*

5. *When a SIP resident isfound guilty of a Class 1 Misconduct related to sexual abuse, or Misconduct #19, the resident shall remain at the SCI and be processed in accordance with the institutional PREA policy, DC-ADM 008, Prison Rape Elimination Act.*

6. *If the allegation is unsubstantiated, unfounded, or the resident isfound not guilty of the misconduct charge(s), they will be returned to community corrections.*

7. *If the investigation reveals the resident is a victim of sexual abuse, they will be returned to community corrections without delay and receive supportive services.*

Disciplinary Sanctions -Federal Residents

1. *When a Federal resident is alleged to have committed sexual abuse, the resident shall be administratively transferred to a Federal Correctional Institution or other designated institution by the Federal Community Corrections Manager or U.S. Probation as <lppropriate.*

2. *The alleged victim of sexual abuse shall not be returned to the FCI or other designated institution.*

Disciplinary Sanctions – Other Assigned Residents (Non-DOC, Non-PBPP, Non-Federal)

1. *When an Other Assigned Resident (OAR),* is *alleged to have committed sexual abuse, the resident shall be separated from the alleged victim.*

2. *The Firetree, Ltd. program shall conduct the administrative investigation, and contact the State Police to*

conduct a criminal investigation for criminal behavior allegations/ incidents.

The facility has not had any incidents where a resident was disciplined. This was confirmed by my interview with the Facility Director.

Standard 115.282 Access to emergency medical and mental health services

D Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

Policy and Procedures Manual Policy # 12-008 Subject: Access to Emergency Medical & Mental Health Services, Forensic Medical Examinations, and Victim Advocate Services, and Follow-up Services. This policy reads as follows:

Scope: This policy is applicable to the governing body, all facility employees, all residents under facility supervision, and to all those individuals and groups that conduct business with or use resources of the facility.

Policy: Resident victims of sexual abuse shall 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. Victims of sexual abuse shall be offered access to a forensic medical examination, and medical and mental health sexual abuse follow-up services.

Procedures:

1. *Upon learning of an allegation that a resident was sexually abused, the first staff member to respond shall take immediate and appropriate steps to ensure the resident's safety and actions to maximize the potential for obtaining usable physical evidence in accordance with Staff First Responder Duties Policy 12-018.*

2. *The PREA Compliance Manager (PCM) shall coordinate medical services related to sexual abuse for their facility and where possible, utilize a hospital that employs a Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE).*

3. *Letters of agreement shall be maintained for forensic medical examinations by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs).*

4. *Staff shall not take any photographs when a sexual abuse allegation is made. The collection of any photographic evidence must be conducted by the outside medical professional or law enforcement.*

5. *On-site medical staff shall not conduct forensic medical exams of residents.*

6. *In order for a forensic medical examination to be performed, the report must be made within 96 hours of the abuse happening. The forensic examination will occur at the hospital in an attempt to try*

to collect anypossible evidence that may bepresent. Because of this, there are several things that one needs to keep in mind.

Even though one may want to clean up after the abuse, it is important to see supervisory staff BEFORE one showers, washes, drinks, eats, smokes, changes clothing, or uses the bathroom. Hospital medical staff will examine the resident for injuries, which may or may not be readily apparent to the resident.

7. *Forensic medical examinations shall be offered to all victims of sexual abuse, without financial cost, where evidentiary and medically appropriate. No financial liability is assumed by Firetree, Ltd. as sexual abuseforensic examinations arefunded in accordance with CFR lltle 28, Chapter 1 Part 90 Subpart B, Section 90.14.*

8. *The PREA Compliance Manager shall coordinate victim services related to theirfacility.*

9. *The PCM shall work with the Pennsylvania Coalition against Rape (PCAR) approved local rape crisis center to establish a Rape Crisis Letter of Agreement for victim advocate and emotional supportive services. These services shall be offered to all sexual abuse victims.*

10. *Notification about available services (attachment 4-C) shall beposted in thefacility common areas accessed by residents. Theposting shall include the addressfor local services, and phone numbers, including toll1ree hotline numbers where available, with written consent of the organization providing the services. Thefacility shall enable reasonable communication between residents and these organizations in as confidential a manner aspossible. Thefacility shall not monitor these communications.*

11. *If the victim rfuses to go to the hospital for forensic examination, the rape crisis center will be asked to help in the matter. Normally with client consent, a rape crisis victim advocate will meet the client at the hospital in the provision of victim advocate services.*

12. *The PREA Compliance Manager (PCM) or designee will accompany the resident during transport to a hospital. The PCM does not necessarily have to travel in the ambulance with the victim, however at a minimum should meet the victim at the hospital. Thepurpose of the PCM presence is toprovide emotional support to the victim by sitting with the victim at the hospital and to ensure theproper coordination with the victim advocate service. The PCM shall not bepresent in theforensic examination room. It ispermissible upon requestfrom the victim, to allow the victim's family to provide the transport to the hospital.*

13. *With the resident's consent, the hospital staff can also test and provide treatmentfor sexually transmitted infections, possible exposure to diseases such as HIV and Hepatitis, and gather any physical evidence of abuse.*

14. *Females may be testedfor pregnancy at the hospital when appropriate.*

15. *Residents who are victim of an abuse by staff or other resident(s) may seek counseling and/or advice from a psychologist or chaplain. Crisis counseling, coping skills, suicide prevention and mental health counseling are to be available to the resident. Most individuals need help to recoverfrom the emotional effects of sexual abuse. Rape crisis victim advocates serve to accompany and support the victim through theforensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, iriformation, and referrals.*

16. *To the extent Firetree, Ltd. itself is not responsible for investigating allegations qf sexual abuse it*

shall request that the investigating agencyfollow the requirements setforth in this policy. This request shall be documented.

Follow-up Services:

1. *The PCM shall coordinate medical and mental health evaluations and, as appropriate, treatmentfor all residents who have been victimized by sexual abuse in anyprison, jail, lockup, juvenile facility, or community confinement facility. This includesfollow-up services, treatment plans, and referrals for continued carefollowing their release from thefacility.*

2. *The PCM shall coordinate medical services and referrals for treatment in the community, in accordance with professionally accepted standards, to include: offered pregnancy testsfor resident victims of sexually abusive vaginal penetration during incarceration, timely and comprehensive information about and access to emergency contraception; lawfitl pregnancy-related services (if pregnancy resultsfrom sexually abusive vaginal penetration); Sexually Transmitted Infections (STI) testing andfollow-up treatment.*

3. *Medical and mental health referrals shall occur to locations providing servicers consistent with the community level of care.*

4. *Thefacility shall attempt to have a mental health evaluation conducted of all known resident-on-resident abusers within 60 days of learning such abuse history and offer treatment when deemed appropriate by mental health practitioners.*

5. *Services shall be provided withoutfinancial cost to the victim regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. This.financial obligation ends when the resident is released from thefacility.*

The Facility Director related that he understood the policy relating to Access to Emergency Medical & Mental Health Services.

No incidents at the facility have occurred where these services were utilized. This was confomed by my interview with the Facility Director.

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

D Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

Policy and Procedures Manual Policy # 12-008 Subject: Access to Emergency Medical & Mental Health Services, Forensic Medical Examinations, and Victim Advocate Services, and Follow-up Services.

Follow-up Services:

1. *The PCM shall coordinate medical and mental health evaluations and, as appropriate, treatment.for all residents who have been victimized by sexual abuse in any prison, jail, lockup, juvenile facility, or community confinement facility. This includesfollow-up services, treatment plans, and referrals for continued carefollowing their releasefrom thefacility.*

2. *The PCM shall coordinate medical services and referrals for treatment in the community, in accordance with professionally accepted standards, to include: offered pregnancy testsfor resident victims of sexually abusive vaginal penetration during incarceration, timely and comprehensive information about and access to emergency contraception; lawful pregnancy-related services (if pregnancy resultsfrom sexually abusive vaginal penetration); Sexually Transmitted Infections (STI) testing and follow-up treatment.*

3. *Medical and mental health referrals shall occur to locations providing servicers consistent with the community level of care.*

4. *Thefacility shall attempt to have a mental health evaluation conducted of all known resident-on-resident abusers within 60 days of learning such abuse history and offer treatment when deemed appropriate by mental health practitioners.*

5. *Services shall be provided withoutfinancial cost to the victim regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Thisfinancial obligation ends when the resident is released.from thefacility.*

The Facility Director related that he understood the policy relating to Access to Emergency Medical & Mental Health Services.

No incidents at the facility have occurred where these services were utilized. This was confirmed by my interview with the Facility Director.

Standard 115.286 Sexual abuse incident reviews

[x] 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)

EVIDENCE OF COMPLIANCE:

Policy and Procedures Manual Policy # 12-027 Subject: Sexual Abuse Incident Reviews establishes the procedures for incident reviews. This policy reads as follows:

Scope: Thispolicy is applicable to the governing body, designated investigator,facility director, and other designated manager or supervisory staff

Policy: A Sexual Abuse Incident Review shall be conducted at the conclusion of every sexual abuse investigation where the allegation was substantiated or unsubstantiated. No review will be conducted if the allegation has been

determined to be unfounded. The review shall occur within 30 working days of notice of satisfactory completion of the investigation. These reviews must takeplace for ALL sexual abuse investigations, whether they are conducted by the Bureau Security Division, Office of Special Investigations and Intelligence (OSII), or applicable Department of Justice investigatory entity.

Procedures:

10. *The Prison Rape Elimination Act (PREA) Compliance Manager (PCM) will chair the Sexual Abuse Incident Review Committee. The PCM, in collaboration with the Regional Director/ designee (DOC) or the Community Corrections Manager/ designee (Federal BOP), will determine the exact composition of the team based upon the nature of the incident. The Sexual Abuse Incident Review Team may involve the following individuals:*
    - *Facility Director/ designee;*
    - *COO and other applicable managers or supervisors;*
    - *Investigator;*
    - *Facility Counselor (presence not authorized for stqff-on-resident accusations;*
    - *Facility medical/ mental health practitioner (only if directly involved) and*
    - *Firetree, Ltd. PREA Coordinator*

11. *The PCM shall ensure all necessary documents are available for review (residentfile, investigative packet, etc.) and notifj; the review team of the date, time, and place for the meeting.*

12. *The Sexual Abuse Incident Review must occur at thefacility where the incident occurred. ...*

13. *The team will carefully review the documentation surrounding the incident. The review team willfocus upon the events associated with the incident, such as housing assignment, location of the alleged incident, measures taken as a result of the allegation, needfor follow-up for the victim, etc.*

14. *The review committee will consider, at a minimum, the items outlined in the PREA Sexual Abuse Incident Review (Attachment 6-A).*

15. *In addition to reviewing the information surrounding the incident, the team will also gather information that can help sensitize staff to possible clues and situations that are present before such incidents may occur. The aim is to help all staff become more proficient at detecting preventable incidents before they occur.*

16. *The Sexual Abuse Incident Review Committee shall utilize all available information and reports to:*
    a) *Consider whether the incident or investigation indicates a need to change policy orpractice to better prevent, detect, or respond to sexual abuse;*
    b) *Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, orperceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at thefacility;*
    c) *Examine the area of thefacility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;*
    d) *Assess the adequacy of staffing levels in that area during different shifts;*
    e) *Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff;*
    f) *Take action necessary to address immediate safety concerns;*
    g) *Utilize PREA Sexual Abuse Incident Review toprepare a confidential report with findings and recommendations; and*

h) Forward the completed report with attachments via e-mail to the BCC Investigator (for DOC related reviews) and Facility Director/ designee withinfive worldng days of the incident review.

17. The designated investigator shall ensure completeness of thepacket and provide to the Bureau Director, Community Corrections Manager (CCM), or Other Assigned Residents (OAR) designeefor review and feedback.

Feedback:

I. Withinfive working days of receipt, the DOC Bureau Director, or designee shall review thefindings, and:

2. The DOC 'sPREA Committee, chaired by the Executive Deputy Secretary/ designee and the DOC 's PREA Coordinator/ designee will review the Sexual Abuse Incident Reviews in accordance with DOC Department policy, DC-ADM 008, and provide feedback to the BCC accordingly.

3. The DOC Bureau Director/ designee shall ensure the recommendations for improvement made by the DOC 's Department PREA Committee are implemented by thefacility, or shall provide documentation to the Executive Deputy Secretary, and the Department PREA Coordinator of reasons for not doing so.

4. The DOC Bureau Director/ designee shall ensure a copy of thefinal report isprovided to the Regional Director, designeefor distribution to the Facility Director/ designee and PCM

5. The Facility Director/ designee shall implement the recommendations for improvement, or shall document reasonsfor not doing so. The PCM willprovide a copy of the documentation to the Bureau Directorldesignee.

6. (Federal and OAR) Recommendations for improvement receivedfrom the CCM or OAR designee shall be implemented, or reasonsfor not doing so documented.

7. Appropriate information, excluding the co11fidential report, may be usedfor in-service trainingfor appropriate staff. References to and dissemination ofprotected iriformation will be in accordance with DOC Department policy, DC-ADM 003, Release of Information, 255.5 regulations, and HIPM in accordance with state andfederal law.

The Agency PREA Coordinator related that an incident review would be scheduled for any allegation.

I was provided the incident review documentation for the investigations, the incident reviews take into consideration all items enumerated in the policies.

The reviews are being conducted within 30 working days from the completion of the investigation.

Standard 115.287 Data collection

D Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

Policy and Procedures Manual Policy # 12-028 Subject: Data Management establishes the procedures for management, storage and release of data. This policy reads as follows:

Scope: Thispolicy is applicable to the Firetree, Ltd. governing body.

Policy: Firetree, Ltd. shall collect accurate, uniform data for every allegation of sexual abuse atfacilities under its direct control using a standardized instrument and set of definitions.

Procedures:

18. *Firetree, Ltd. 'sgoverning body shall review collected PREA data and ensure it is aggregated annually pursuant to PREA Auditing Standard §115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training by:*
    a) *Identifying problem areas;*
    b) *Taking corrective action on an on-going basis; and*
    c) *Preparing an annual report of itsfindings and corrective actionsfor eachfacility, as well as Fire tree, Ltd. as a whole.*
19. *The incident-based data collected shall include, at a minimum, the data necessary to answer all of the questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice. All data information shall be maintained, reviewed, and collected as needed from all available incident-based documents, including reports, investigationfiles, and sexual abuse incident reviews.*
20. *Firetree, Ltd. will produce an annual PREA report, capturing data from January 1 to December 31, and will provide thefollowing information:*
    a) *The number of allegations made at eachfacility;*
    b) *The number of substantiated, unsubstantiated, and unfounded investigations completed as of December 31 each year;*
    c) *The number of ongoing investigations as of December 31for eachfacility;*
    d) *Comparison of the rates f incidentsfor eachfacility from thepreceding year to the current year;*
    e) *Any additional information that is required by the Survey of Sexual Violence required by the Department of Justice; and*
    j) *The report shall include a comparison of the current year's data and corrective actions taken to reduce the incident f sexual abuse, sexual harassment, and retaliation with thosefrom prior years, and shall provide an assessment of the progress in addressing sexual abuse.*

21. *The PREA annual report shall be approved by the Firetree, Ltd. governing body and made readily available to thepublic through its Website. The agency shall ensure that data collected pursuant to §115.287 are securely retained. Collected sexual abuse data collected pursuant to §115.287 shall be maintained/or at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise.*
22. *Firetree, Ltd. shall utilize the DOC's Annual PREA report to satisfY the PREA standards for any incident*

that involves a (DOC) Department-Funded Resident (DFR) as the victim or abuser. The agency however shall also comply with PREA data collection and reporting requirements of incident-based aggregate data when the incidents involve only Non-Department-Funded Residents (NDFR).

23. *Upon request, Firetree, Ltd. shall provide all such PREA collection data from the previous calendar year to the Department of Justice no later than June 30.*
24. *Before maldng aggregated sexual abuse data publically available, Firetree, Ltd. shall remove all personal identifiers. The agency may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of the facility, but must indicate the nature of the material redacted.*

The policy addresses all enumerated items in the standard. The PREA Coordinator related that the data is collected at the facility level and forwarded to him monthly.

Standard 115.288 Data review for corrective action

Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Standard (requires corrective action)

EVIDENCE OF COMPLIANCE:

Policy and Procedures Manual Policy # 12-028 Subject: Data Management establishes the procedures for management, storage and release of data. This policy reads as follows:

Scope: This policy is applicable to the Firetree, Ltd. governing body.

Policy: Fire tree, Ltd. shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions.
Procedures:

25. *Firetree, Ltd. 'sgoverning body shall review collected PREA data and ensure it is aggregated annually pursuant to PREA Auditing Standard §115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training by:*
    d) Identifying problem areas;
    e) Taking corrective action on an on-going basis; and
    .f] Preparing an annual report of its findings and corrective actions for each facility, as well as Firetree, Ltd. as a whole.

26. *The incident-based data collected shall include, at a minimum, the data necessary to answer all of the questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice. All data iriformation shall be maintained, reviewed, and collected as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.*

27. *Firetree, Ltd. will produce an annual PREA report, capturing data from January 1 to December 31, and will provide the following information:*
    g) The number of allegations made at each facility;
    h) The number of substantiated, unsubstantiated, and unfounded investigations completed as of December 31 each year;

i) The number of ongoing investigations as of December 31for eachfacility;
j) Comparison of the rates of incidents for eachfacility from thepreceding year to the current year;
k) Any additional information that is required by the Survey of Sexual Violence required by the Department of Justice; and
l) The report shall include a comparison of the current year's data and corrective actions taken to reduce the incident of sexual abuse, sexual harassment, and retaliation with thosefrom prior years, and shall provide an assessment of the progress in addressing sexual abuse.

28. The PREA annual report shall be approved by the Firetree, Ltd. governing body and made readily available to thepublic through its Website. The agency shall ensure that data collected pursuant to §115.287 are securely retained. Collected sexual abuse data collected pursuant to §115.287 shall be maintained for at least J O years after the date of the initial collection, unless Federal, State, or local law requires otherwise.

29. Firetree, Ltd. shall utilize the DOC's Annual PREA report to satisfy the PREA standards for any incident that involves a (DOC) Department-Funded Resident (DFR) as the victim or abuser. The agency however shall also comply with PREA data collection and reporting requirements of incident-based aggregate data when the incidents involve only Non-Department-Funded Residents (NDFR).

30. Upon request, Firetree, Ltd. shall provide all such PREA collection data from the previous calendar year to the Department of Justice no later than June 30.

31. Before maldng aggregated sexual abuse data publically available, Firetree, Ltd. shall remove all personal identifiers. The agency may redact specific materialfrom the reports when publication would present a clear and specific threat to the srifety and security of thefacility, but must indicate the nature of the material redacted.

The agency has produced a 2016 Prison Rape Elimination Act Annual Report. This report lists all allegations in the six programs that Firetree, Ltd supervises. The data collected is from all incidents that have occurred in the programs, this would include any allegations that were conducted by the PADOC or Bureau of Prisons. The report compares the aggregated data from 2015 and 2016.

The 2016 report concluded that one policy change was made after incident review meetings were conducted, this policy change was to enhance executive staff notification and resulted in the aforementioned cameras being installed.

Through interviews it was confirmed that if a problem or trend is identified they would immediately implement a corrective action plan.

During the staff interviews I found that data is being forwarded on a monthly basis for review.

Standard 115.289 Data storage, publication, and destruction

D Exceeds Standard (substantially exceeds requirement of standard)

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

D Does Not Meet Stm1dard (requires corrective action)

EVIDENCE OF COMPLIANCE:

Policy and Procedures Manual Policy # 12-028 Subject: Data Management establishes the procedures for management, storage and release of data. This policy reads as follows:

Scope: Thispolicy is applicable to the Firetree, Ltd. governing body.

Policy: Firetree, Ltd. shall collect accurate, uniform datafor every allegation of sexual abuse atfacilities under its direct control using a standardized instrument and set of definitions.

Procedures:

32. Firetree, Ltd. 'sgoverning body shall review collected PREA data and ensure it is aggregated annually pursuant to PREA Auditing Standard §115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training by:

g) Identijj;ing problem areas;

h) Taking corrective action on an on-going basis; and

i) Preparing an annual report of itsfindings and corrective actionsfor eachfacility, as well as Firetree, Ltd. as a whole.

33. The incident-based data collected shall include, at a minimum, the data necessary to answer all of the questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice. All data information shall be maintained, reviewed, and collected as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

34. Firetree, Ltd. will produce an annual PREA report, capturing datafrom January 1 to December 31, and will provide thefollowing information:

m) The number qf allegations made at eachfacility;

n) The number of substantiated, unsubstantiated, and unfounded investigations completed as of December 31 each year;

o) The number of ongoing investigations as of December 31for eachfacility;

p) Comparison of the rates of incidentsfor eachfacility from thepreceding year to the current year;

q) Any additional information that is required by the Survey of Sexual Violence required by the Department of Justice; and

r) The report shall include a comparison of the current year's data and corrective actions taken to reduce the incident of sexual abuse, sexual harassment, and retaliation with thosefrom prior years, and shall provide an assessment of theprogress in addressing sexual abuse.

35. The PREA annual report shall be approved by the Firetree, Ltd. governing body and made readily available to the public through its Website. The agency shall ensure that data collected pursuant to §115.287 are securely retained. Collected sexual abuse data collected pursuant to §115.287 shall be maintained for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise.

36. Firetree, Ltd. shall utilize the DOC's Annual PREA report to satisfy the PREA standards for any incident that involves a (DOC) Department-Funded Resident (DFR) as the victim or abuser. The agency however shall also comply with PREA data collection and reporting requirements of incident-based aggregate data when the incidents involve only Non-Department-Funded Residents (NDFR).

37. Upon request, Firetree, Ltd. shall provide all such PREA collection datafrom theprevious calendar year to the Department of Justice no later than June 30.

38. Before maldng aggregated sexual abuse data publically available, Firetree, Ltd. shall remove allpersonal identifiers. The agency may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of thefacility, but must indicate the nature of the material redacted.

All of the data collected by the agency is kept on a secure server with limited access. I reviewed the issued 2016 PREA Annual Report and found it to be complete, all data is contained within the rep01i, and all identifiers have been removed.

AUDITOR CERTIFICATION
I certify that:

- O The contents of this report are accurate to the best of my knowledge.
- O No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- O 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.

Olgltally signed by PatrkkJ Zlrpoll
DN:cn=PatrickJ Zlrpoll, o=PatrlckJ.ZlrpolJ lie, ou=PREA Auditor, email=pjz6896@ptd.net, C!"US
Date: 2017.06.05 13:45:07 -04'00'

06/05/17

Auditor Signature Date