Prison Rape Elimination Act (PREA) Audit Report
Juvenile Facilities

☐ **Interim** ☒ **Final**

Date of Report 12/31/2020

Auditor Information

Name: James L. Roland Jr.	**Email:** james.roland@nakamotogroup.com
Company Name: The Nakamoto Group, Inc.	
Mailing Address: 11820 Parklawn Drive, Suite 240	**City, State, Zip:** Rockville, MD. 20852
Telephone: 301-468-6535	**Date of Facility Visit:** 11/10-11/2020

Agency Information

Name of Agency Generations Group		**Governing Authority or Parent Agency** *(If Applicable)* Click or tap here to enter text.	
Physical Address: 820 Dunklin Bridge Road		**City, State, Zip:** Fountain Inn, SC. 29644	
Mailing Address: P.O. Box 80009		**City, State, Zip:** Simpsonville, SC. 29680	
Telephone: 864-243-5557		**Is Agency accredited by any organization?** ☐ Yes ☒ No	
The Agency Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

Agency mission: Generations is committed to the prevention of sexual abuse by providing best practice in assessment and services for neglected or at-risk youth and their families

Agency Website with PREA Information: http://www.generationsgroup.com/

Agency Chief Executive Officer

Name: Michaela Horvath	**Title:** Interim Executive Director
Email: michaela@generationsgroup.com	**Telephone:** 864-243-5557 ext. 217

Agency-Wide PREA Coordinator

Name: Heather A. Smith	**Title:** PREA Compliance Director
Email: heather@generationsgroup.com	**Telephone:** 864-243-5557 ext 222

PREA Coordinator Reports to: Michaela Horvath, Interim Executive Director	Number of Compliance Managers who report to the PREA Coordinator 0

Facility Information

Name of Facility: Generations Alternative Programs				
Physical Address: 820 Dunklin Bridge Road, Fountain Inn, SC 29644				
Mailing Address (if different than above):				
Telephone Number: 864-243-5557				
The Facility Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit	
☐ Municipal	☐ County	☐ State	☐ Federal	
Facility Type:	☐ Detention	☒ Correction	☐ Intake	☐ Other

Facility Mission:
Generation's mission is to prevent sexual abuse by helping neglected and/or at-risk adolescent and pre-adolescent males overcome abusive behaviors.

Facility Website with PREA Information: www.generationsgroup.com

Is this facility accredited by any other organization? ☒ Yes ☐ No Council on Accreditation (COA)

Facility Administrator/Director

Name: Chris Leach	**Title:** Director
Email: chris@generationsgroup.com	**Telephone:** 864-243-5557 ext. 512

Facility PREA Compliance Manager

Name: Heather Smith	**Title:** PREA Compliance Director
Email: heather@generationsgroup.com	**Telephone:** 864-243-5557 ext. 222

Facility Health Service Administrator

Name:	**Title:**
Email:	**Telephone:**

Facility Characteristics

Designated Facility Capacity: 26	**Current Population of Facility:** 19
Number of residents admitted to facility during the past 12 months	18

Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 10 days or more:	18
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:	18
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:	0
Age Range of Population:	14-20
Average length of stay or time under supervision:	357 Days
Facility Security Level:	n/a
Resident Custody Levels:	Minimum
Number of staff currently employed by the facility who may have contact with residents:	44
Number of staff hired by the facility during the past 12 months who may have contact with residents:	12
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	0

Physical Plant

Number of Buildings: 6	**Number of Single Cell Housing Units:** 0
Number of Multiple Occupancy Cell Housing Units:	0
Number of Open Bay/Dorm Housing Units:	2
Number of Segregation Cells (Administrative and Disciplinary:	0

Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.): Generations Alternative Program (GAP) utilizes a video camera system for video surveillance. Cameras are placed strategically throughout the complex to ensure the safety and security of both residents and staff.

Medical

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

Other

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

Audit Findings

Audit Narrative

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

Overview

The on-site Prison Rape Elimination Act (PREA) compliance audit of Generations Alternative Program (GAP) located in Fountain Inn, South Carolina was conducted on November 10-11, 2020 by U.S. Department of Justice (DOJ) certified PREA Auditor, James L. Roland Jr., Nakamoto Group, Inc. The standards used for this audit became effective August 20, 2012. The Auditor conducted an opening meeting, toured the entire facility, interviewed a randomized sample of staff and residents, and reviewed PREA related staff and resident documentation. Upon completion of the audit process, a closing meeting was held with the administrative staff to discuss the audit process, preliminary findings, and the post-audit process. Employees at the facility were found to be extremely courteous, cooperative, and professional. All areas of the facility were clean and well maintained. During the completion meeting, the Auditor thanked the staff for their hard work and dedication to the PREA process.

Pre-Audit Phase

On August 17, 2020, PREA Audit Notices in English and Spanish were provided to the facility to be posted. The Auditor observed the notices posted in the living units, at the main entrance, and in the visitation area. The notices were posted for eight weeks pre-audit and the Auditor did not receive any correspondence from residents prior to the on-site visit.

GAP staff were asked to complete the Pre-Audit Questionnaire (PAQ) also provided to the facility on August 20, 2020. The completed PAQ and supporting documentation was received by the Auditor on August 24, 2020. All documentation was reviewed by the Auditor including educational materials, training logs, posters, brochures, agency policies and procedures, forms, organizational charts, and other PREA related documentation.

On August 27, 2020, the Auditor requested additional information including, but not limited to, staff rosters, resident rosters, investigations for review, residents self-identified as Lesbian, Gay, Bisexual, Transgender, Intersex (LGBTI), resident reports of sexual abuse/harassment, residents who are Limited English Proficient (LEP), and additional examples of the GAP screening instrument. These documents were provided and reviewed at the time of the audit.

On-Site Audit Phase

The Auditor held an opening meeting on the morning of November 10, 2020 at the GAP facility with administrative staff. The audit schedule and process were discussed during the meeting. Including the Auditor, those present at the meeting were:

- CEO
- Director

- PREA Compliance Director/PREA Compliance Manager (PCM)
- Facilities Director (FD)

The Auditor was provided a private conference room in which to work and conduct confidential interviews. All requested files and rosters, both staff and residents were made available to the Auditor for review.

Site Review

Immediately following the opening meeting, a tour of the facilities was completed. The Auditor was escorted by the PCM, and FD. During the tour, the Auditor reviewed PREA related documentation and materials located on bulletin boards, and other locations. The Auditor assessed camera surveillance, physical supervision, and electronic monitoring capabilities. Other areas of focus during the facility tour included, but were not limited to, levels of staff supervision, and limits to cross-gender viewing. All signs and postings were in both English and Spanish. Residents can shower, dress, and use the toilet facilities without exposing themselves to employees of the opposite gender. Informal and formal conversations with employees and residents regarding the PREA standards were conducted. Postings regarding PREA violation reporting and the agency's zero-tolerance policy for sexual abuse and sexual harassment were prominently displayed in all living units, meeting areas, and throughout the facility. Audit notice postings with the PREA Auditor's contact information were posted in the same areas. The Auditor notice postings were posted eight weeks prior to the on-site visit. Unimpeded access to all areas of the facility was provided to the Auditor.

Resident Interviews

At the time of the audit, there were 19 male residents housed at the GAP. A total of 15 residents were interviewed. The facility indicated that they had no residents with Limited English Proficiency (LEP), no residents who self-identified as LGBTI, no residents who reported sexual victimization during risk screening, and no residents with cognitive or physical disabilities were interviewed. No residents refused to be interviewed. Interviews were conducted using the Department of Justice (DOJ) protocols to determine residents' knowledge of PREA and the reporting mechanisms available to them.

Staff Interviews

GAP employs a staff of 44 individuals of which 20 staff members were interviewed, including nine random staff, (from all three shifts), and 11 administrative/specialized staff. The administrative staff included the CEO, Director, and the PCM. Specialized staff included the Program Coordinator, Clinical Manager, Human Services Professional (HSP), Health Services Professional (HSP), Facility Director, Staff Development Coordinator, Shift Supervisor. All staff have been trained to act as first responders when a PREA related incident occurs.

The Auditor reviewed email correspondence with the victim advocacy center (Julie Valentine Center) regarding advocacy services. It was confirmed that they will provide services to GAP residents including, but not limited to, a 24 hour per day, seven days per week Sexual Assault

Hotline, and advocacy for a resident victim of sexual assault, however. The Center will not enter into any type of official agreement. The Auditor connected telephonically with emergency room representative at Prisma Health Systems (PHS) and confirmed that forensic examinations by a Sexual Assault Nurse Examiner (SANE) is available 24/7.

File Review

Following the interviews, the Auditor reviewed the files requested during the pre-audit phase. The Auditor reviewed five personnel files to establish compliance with PREA training mandates and background checks. Screening and intake procedures were evaluated by reviewing five random resident files which included a vulnerability assessment instrument and resident education verification documentation.

Investigations

During the current auditing period, there was one reported allegation of sexual abuse and no allegations of sexual harassment. The above mentioned allegation was substantiated. All investigations are handled by the County Sheriff's Department. Information is transmitted quickly to the appropriate investigating agency through the Event Reporting Management Information System (ERMIS). The PCM is responsible for receiving verbal and telephonic referrals 24 hours a day, seven days a week. Additionally, abuse investigation outcomes and general protective services assessment outcomes are submitted to, reviewed by, and finalized by the PCM and forwarded to the agency CEO.

Closeout

A closing meeting was held with the Auditor and the administrative staff on the evening of November 11, 2020. Discussions centered around the audit process, preliminary findings, and the post-audit process. The Auditor thanked the staff for their hard work and dedication to the PREA process.

Facility Characteristics

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

The Program

Generations Alternative Program, Inc. was founded in 1998 and is located in the upstate of South Carolina. Generations' philosophy is that intervention for pre-adolescents and adolescents who engage in sexually abusive behaviors significantly reduces the risk of further victimization by these individuals and that perpetration prevention is primary sexual abuse prevention. In agreement that these youths should be placed in the least restrictive

environment possible, Generations provides residential Group Care Intensive Services and Group Care Intermediate Services for youth with sexually abusive behaviors.

Generations' programs serve adolescent males statewide who are in primary need of services for sexually abusive behaviors in a highly structured setting. These children are unable to live in a less restrictive environment due to the intensity or severity of their current behavioral, emotional and/or acting out behaviors.

Overarching Philosophy

Generations Alternative Program, Inc. contracts with the SC Department of Juvenile Justice to provide Group Care Intensive Services and Group Care Intermittent Services to adolescent males who have problems with sexually abusive behaviors. The community based Group Care Intensive Services home serves 16 adolescent males and the Group Care Intermittent Services program serves 10 adolescent males aged 12 through 20 who have a documented history of sexually abusive behaviors.

Generations provides these services through a structured, staff-secure, rehabilitative program in a home-like setting. The goal of the program is to enable children to overcome their problems to the degree that they may be safely returned to their home community or stepped down to a less restrictive environment. Sexual behavior management and various skill-building groups are tailored to the specific needs of each adolescent. Non-sexual abusive, aggressive, and exploitive behaviors are also addressed through a diverse range of strategies centered on the positive peer milieu.

Summary of Audit Findings

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

Overview

During the auditing period, GAP reported one incident of sexual abuse/harassment in the Pre-Audit Questionnaire (PAQ). There is a well-established zero-tolerance culture throughout with documentation addressing all areas of PREA. The agency and the GAP maintains a detailed set of policies for the facility. A random review of five personnel files for background checks and employee training files established compliance with PREA training mandates and revealed that hiring and promotion practices are consistent with sexual abuse safety measures.

The Auditor found the facility administration maintaining a strong commitment to PREA and the zero-tolerance policy. Significant time and resources have been employed to ensure a sexually safe environment for the residents of the GAP. From the pre-audit phase to the completion of the on-site visit, the corrections professionals at the GAP proved to be organized, efficient, and well-prepared.

Staff Interviews

Interviews with 25 staff revealed they received and had a good understanding of PREA policies. Interviews were conducted with ten specialized staff. These staff consisted of the Chief Executive Officer (CEO), Program Director (PD), PREA Compliance Manager (PCM), Human Services Professional (HSP), Facility Director (FD), and Staff Development Coordinator (SDC). Some staff have multiple responsibilities and were interviewed multiple times to fulfill the audit protocols. Fifteen random staff were interviewed which consisted of direct care staff from all shifts. They were knowledgeable about their roles in prevention, reporting, and their responsibilities in the event of a PREA related incident, particularly first responder duties. They were able to verbalize the steps they would take if they were the first responder to a PREA related incident. Reporting mechanisms were displayed in a conspicuous manner and residents and staff members were aware of all reporting methods available to them. A review of the GAP staff training curriculum was completed by the Auditor and records support the finding that all staff have received comprehensive PREA training. Staff appeared truly interested and vested with the residents and expressed a true desire to see them succeed.

Resident Interviews

The GAP only houses male residents. Fifteen residents were interviewed and they each revealed that they have a good understanding of the PREA safeguards and the zero-tolerance policy. Comprehensive resident PREA education is provided in written form (Resident PREA Handbook and Entrance Packet), personal instruction, and posters. The facility indicated that they have no residents self-identified as LGBTI, no residents who were physically disabled, no residents who reported a sexual abuse (that were still at the facility), and no residents who disclosed prior sexual victimization during risk screening. Five vulnerability assessment instruments were reviewed by the Auditor which indicated that intake and classification assessments are efficient and seamless in addressing referrals based on victimization or abusiveness screening data. Residents acknowledged the admissions screening process included questions regarding any history of sexual abuse or victimization and whether they would like to identify a sexual preference. Residents expressed, during interviews, that they were aware of how to report abuse internally and externally. Residents verbalized trust in the GAP staff and a willingness to report abuse to them. The residents demonstrated understanding that the facility has appropriate medical and victim advocacy networks in place. Residents affirmed they felt safe in the facility. Staff and resident interactions were observed by the Auditor and appeared respectful and positive.

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

Number of Standards Exceeded: 0

Number of Standards Met: 43

- §115.311; §115.312; §115.313; §115.315; §115.316; §115.317; §115.318
- §115.321; §115.322
- §115.331; §115.332; §115.333; §115.334; §115.335
- §115.341; §115.342; §115.343
- §115.351; §115.352; §115.353; §115.354
- §115.361; §115.362; §115.363; §115.364; §115.365; §115.366; §115.367; §115.368
- §115.371; §115.372; §115.373; §115.376; §115.377; §115.378
- §115.381; §115.382; §115.383; §115.386; §115.387; §115.388; §115.389
- §115.401; §115.403

Number of Standards Not Met: 0

Summary of Corrective Action (if any)

Concern #1- Standard 115.313: Female staff did not announce themselves when entering the male living units.

Corrective Action: Policy and procedures were written to require staff of the opposite gender announce themselves upon entering all living units. The facility provided the Auditor with 30 days of training documentation after the onsite portion of the audit which brought this standard into compliance.

Concern #2- Standard 115.315: Mid and/or higher level staff do no conduct unannounced rounds.

Corrective Action: Policy and/or procedure was written to include unannounced rounds. The facility provided the Auditor with 30 days of documentation of training and implementation after the onsite portion of the audit which brought this standard into compliance.

PREVENTION PLANNING

Standard 115.311: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

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

115.311 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual

abuse and sexual harassment? ☒ Yes ☐ No

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

115.311 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator? ☒ Yes ☐ No
- Is the PREA Coordinator position in the upper-level of the agency hierarchy? ☒ Yes ☐ No
- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities? ☒ Yes ☐ No

115.311 (c)

- If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.) ☒ Yes ☐ No ☐ NA
- Does the PREA compliance manager have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards? (N/A if agency operates only one facility.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. GAP 3.41 PREA Compliance
3. GAP Organizational Chart
4. Resident PREA Handbook
5. 2020 Staffing Plan

6. NO means NO - PREA Poster
7. Zero Tolerance - PREA Poster
8. Interviews with the following:
    a. Specialized and Random Staff

The agency's zero-tolerance policy against sexual abuse was clearly established in the above documentation and via interviews. The agency's zero-tolerance toward sexual abuse is clearly established and the policy also outlines the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment allegations. The Compliance Director serves as the PCM and the PREA Coordinator. The PCM reports to the CEO. Zero-tolerance posters are displayed throughout every area of the complex. The agency and facility directives outline a zero-tolerance policy for all forms of sexual abuse and sexual harassment. Residents are informed orally about the zero-tolerance policy and the PREA program during in-processing and are required to view a video during admission and orientation presentations. Additional program information is contained in the Resident PREA Handbook and is posted throughout the facility, as observed during the tour by this Auditor. PREA information is also provided to the resident in the intake packet. All PREA information, both video and written, is available in English and Spanish. Interpretive services are available for residents who do not speak or read English or Spanish. Both institution staff and residents are provided with multiple opportunities to become informed of PREA policies and procedures. All employees receive initial training and Annual Refresher Training (ART), as well as updates throughout the year.

Corrective action: None required

Standard 115.312: Contracting with other entities for the confinement of residents

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

115.312 (a)

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

115.312 (b)

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents OR the response to 115.312(a)-1 is "NO".) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. Interviews with the following:
    a. Specialized Staff

GAP does not contract with other entities for the confinement of its residents.

Corrective action: None required

Standard 115.313: Supervision and monitoring

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

115.313 (a)

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

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

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

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The prevalence of substantiated and unsubstantiated incidents of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Generally accepted juvenile detention and correctional/secure residential practices? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any judicial findings of inadequacy? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from Federal investigative agencies? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The composition of the resident population? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The number and placement of supervisory staff? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Institution programs occurring on a particular shift? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any applicable State or local laws, regulations, or standards? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any other relevant factors? ☒ Yes ☐ No

115.313 (b)

- Does the agency comply with the staffing plan except during limited and discrete exigent circumstances? ☒ Yes ☐ No

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

115.313 (c)

- Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA

- Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA

- Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA

- Does the facility ensure only security staff are included when calculating these ratios? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA

- Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph? ☒ Yes ☐ No

115.313 (d)

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

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns? ☒ Yes ☐ No

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

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan? ☒ Yes ☐ No

115.313 (e)

- Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

- Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

- Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. GAP 3.41 PREA Compliance
3. GAP 3.27 Headcounts and Safety Verification
4. Employee Handbook
5. Master Schedule
6. Staffing Plan Assessment GAP 2020
7. Monitoring Refresher
8. Interviews with the following:
    a. Specialized and Random Staff

Agency policy requires each facility to review the staffing plans on an annual basis. Interviews with the CEO Designee revealed compliance with the PREA and that other safety and security issues are always a primary focus when considering and reviewing respective staffing plans. The CEO meets weekly with his administrative staff including the PCM to address staffing issues as it relates to the PREA. The facility has been provided with all necessary resources to support the programs and procedures to ensure compliance with PREA standards. The audit included an examination of all video monitoring systems, resident access to grievance forms, staff interviews, and rosters. Supervisory and administrative staff routinely make unannounced rounds covering all shifts but these rounds are not documented. The GAP uses of a number of video cameras to monitor the facility. These cameras were pointed out during the tour.

Corrective action: Unannounced rounds were not documented. A policy was written to implement unannounced rounds. The facility provided the Auditor with 30 days of training documentation after the onsite portion of the audit which brought this standard into compliance.

Standard 115.315: Limits to cross-gender viewing and searches

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

115.315 (a)

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

115.315 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances? ☒ Yes ☐ No ☐ NA

115.315 (c)

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

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

115.315 (d)

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

- Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit? ☒ Yes ☐ No

- In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units) ☒ Yes ☐ No ☐ NA

115.315 (e)

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

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

115.315 (f)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. Policy GAP 3.40 Searches and Contraband
3. Policy GAP 3.41 PREA Compliance
4. PREA Training Curriculum
5. Interviews with the following:
    a. Specialized and Random Staff

Policies and documentation address this standard. Cross-gender strip or cross-gender body cavity searches are prohibited. Staff interviews indicated that the GAP is a "no touch" facility. No pat down searches are conducted. If in the event a pat down search is required, law enforcement is called to conduct the search. The Auditor observed that each unit has individual shower stalls. One youth is permitted to shower at a time. Scheduling of showers is

monitored by staff. Through interviews and observations, it was determined that all staff working on the unit do not announce themselves prior to entering the unit, thus not allowing residents the opportunity to prepare themselves from a privacy perspective. It should be noted that all residents are required to change clothes and dress in the private bathrooms. The staff of opposite genders are not able to see residents getting dressed.

The residents interviewed acknowledged they can shower and use the toilet privately, without being viewed by staff of the opposite gender. Due to the open dormitory setting and the lack of staff announcement, it would be possible for staff of the opposite gender to view residents while they dress. Staff, along with a majority of the residents interviewed, indicated that employees of the opposite gender do not announce their presence before entering a housing unit. Staff members were aware of the policy prohibiting the search of a transgender or intersex inmate for the sole purpose of determining the inmate's genital status. During the past 12 months, there were no exigent circumstances that required cross-gender viewing of an resident by a staff member at the GAP.

Corrective action: Policy and procedures were written to require staff of the opposite gender announce themselves upon entering all living units. The facility provided the Auditor with 30 days of training documentation after the onsite portion of the audit which brought this standard into compliance.

Standard 115.316: Residents with disabilities and residents who are limited English proficient

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

115.316 (a)

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

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

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

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

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

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

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

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

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

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

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

115.316 (b)

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

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

115.316 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. Policy GAP 3.41 PREA Compliance
3. PREA Brochure - English
4. PREA Brochure - Spanish
5. LanguageLine Solutions
6. LanguageLine Explanation
7. Interviews with the following:
   Specialized and Random Staff

The GAP takes appropriate steps to ensure residents with disabilities and residents who are LEP have an opportunity to participate in and benefit from the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. PREA handouts, bulletin board postings, and Resident PREA Handbooks are in both English and Spanish. The above mentioned documents were submitted to and reviewed by the Auditor. Staff members interviewed were aware of the policy that, under no circumstances, are resident interpreters or assistants to be used when dealing with PREA issues. Translation services are provided by LanguageLine Solutions and are available to residents who do not have a basic command of the English language. There were no LEP residents at the facility at the time of the audit. The review of documentation, staff, and resident interviews support a finding that the facility is in compliance with this standard.

Corrective action: None required

Standard 115.317: Hiring and promotion decisions

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

115.317 (a)

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

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

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

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

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

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

115.317 (b)

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

115.317 (c)

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

- Before hiring new employees, who may have contact with residents, does the agency: Consult any child abuse registry maintained by the State or locality in which the employee would work? ☒ Yes ☐ No

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

115.317 (d)

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

- Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

115.317 (e)

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

115.317 (f)

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

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

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

115.317 (g)

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

115.317 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. Policy GAP 3.41 PREA Compliance
3. Policy GAP 1.10 Harassment
4. Policy GAP 1.20 Recruitment and Selection
5. Policy GAP 1.30 South Carolina State Law Enforcement Division (SLED) Background Screening
6. SLED Explanation document
7. Interviews with the following:
    a. Specialized and Random Staff

Policies and interviews confirm compliance with this standard. Five employee files were reviewed for the components of this standard. The Human Resource Professional was interviewed, she stated that all components of this standard have been met. Background checks have been completed on all employees, contractors, and volunteers. The GAP conducts background checks. Background checks must be passed before approving staff hiring or promotions. A tracking system is in place to ensure that updated background checks are conducted every year. Policy clearly states the submission of false information by any applicant is grounds for termination. The agency makes its best efforts to contact all prior institution employers for information on substantiated allegations of sexual abuse or resignations occurring during a pending investigation of sexual abuse. The agency also provides information on substantiated allegations of sexual abuse/sexual harassment involving former employees, when requested by a potential institutional employer, unless prohibited by law. Appropriate licensing and certifying agencies are notified, when professional employees are terminated for substantiated allegations of sexual abuse/sexual harassment. Documentation on file supports a finding that the facility is in compliance with this standard.

Corrective action: None required

Standard 115.318: Upgrades to facilities and technologies

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

115.318 (a)

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

115.318 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. Policy GAP 3.41 PREA Compliance
3. Camera Layout
4. Interviews with the following:
   a. CEO designee
   b. PCM

Policies and interviews confirm compliance with this standard. There have been no modifications or upgrades during the auditing period. GAP utilize a video camera system for

video surveillance. Cameras are placed strategically throughout the complex to ensure the safety and security of both residents and staff.

Corrective action: None required

RESPONSIVE PLANNING

Standard 115.321: Evidence protocol and forensic medical examinations

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

115.321 (a)

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

115.321 (b)

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

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

115.321 (c)

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

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

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

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

115.321 (d)

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

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

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

115.321 (e)

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

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

115.321 (f)

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

115.321 (g)

- Auditor is not required to audit this provision.

115.321 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.321(d) above.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. Policy GAP 3.41 PREA Compliance
3. Policy GAP 3.29 Staff Boundaries and Reporting Allegations of Abuse
4. Out of Home Abuse and Neglect (OHAN) Brochure
5. Correspondence attempts with Julie Valentine Center (JVC) for Memorandum of Understanding (MOU)
6. Prisma Health System (PHS) ER Internal Policy
7. Event Reporting Management Information System (ERMIS)
8. Interviews with the following:
    a. Specialized and Random Staff

Policies and interviews confirm compliance with this standard. The facility medical services are conducted at Prisma Health System (PHS) which includes forensic medical examinations if needed. All staff has been trained in evidence protocol. In the event of a sexual assault, the shift supervisor is called, then the PCM. The CEO determines when the resident should be transported to the hospital for a forensic examination and any other medical services required by a trained Sexual Assault Nurse Examiner (SANE) or a trained Sexual Assault Forensic Examiner (SAFE). The facility has attempted to get a signed agreement with Julie Valentine Center (JVC) to provide quality and comprehensive services for survivors of sexual assault. Procedure states that once a resident is transported to PHS the victim advocate center is called to provide victim advocacy services. The organization has agreed to provide service without a signed agreement. There is Hotline number posted in each housing unit. All information is immediately reported to the ERMIS. This information is disseminated to multiple agencies including Out of Home Abuse and Neglect (OHAN). OHAN is a branch of the South Carolina Department of Social Services which investigates allegations of abuse and neglect in residential care facilities. All criminal investigations are conducted by the Greenville County Sheriff's Department in conjunction with OHAN.

Corrective action: None required

Standard 115.322: Policies to ensure referrals of allegations for investigations

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

115.322 (a)

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

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

115.322 (b)

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

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

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

115.322 (c)

- If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? [N/A if the agency/facility is responsible for criminal investigations. See 115.321(a).]
  ☒ Yes ☐ No ☐ NA

115.322 (d)

- Auditor is not required to audit this provision.

115.322 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. Policy GAP 3.41 PREA Compliance
3. Policy GAP 3.22 Incident Reports
4. Policy GAP 3.29 Staff Boundaries and Reporting Allegations of Abuse
5. Out of Home Abuse and Neglect (OHAN) Brochure
6. Interviews with the following:
    a. Random and Specialized Staff

Staff members were interviewed concerning this standard and all were knowledgeable of the procedures required to secure and obtain usable physical evidence when sexual abuse is alleged. Staff were also aware that either the Greenville Sheriff's Department and/or OHAN investigates all sexual abuse allegations. All forensic medical examinations are conducted by trained examiner PHS. An telephonic interview with the SAFE/SANE representative at PHS was conducted and the provider is aware of the provisions of the PREA standards. The representative indicated that a SANE/SAFE is available 24 hours a day, seven days a week. There were no sexual assault examinations conducted during the past 12 months. RAINN (Rape, Abuse and Incest National Network) and JDI (Justice Detention International), national victim advocacy agencies, were contacted by this Auditor, but neither had information related to GAP. The rape crisis center JVC is automatically contacted by PHS when any forensic medical treatment is conducted.

Corrective action: None required

TRAINING AND EDUCATION

Standard 115.331: Employee training

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

115.331 (a)

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in juvenile facilities? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: The common reactions of juvenile victims of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: Relevant laws regarding the applicable age of consent? ☒ Yes ☐ No

115.331 (b)

- Is such training tailored to the unique needs and attributes of residents of juvenile facilities? ☒ Yes ☐ No

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

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

115.331 (c)

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

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

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

115.331 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. Policy GAP 3.41 PREA Compliance
3. Policy 4.05 Code of Conduct
4. Policy 1.17 Employee Orientation
5. PREA sign-in training examples
6. Mandated Reporter Guide
7. Employee training logs examples
8. 2020 Training Log
9. PREA Staff Training Packet
10. PREA Training Module Curriculum
11. Interviews with the following:
    a. Specialized and Random Staff

GAP provides extensive PREA training at the facility. All newly hired employees must attend and successfully complete the course curriculum. All employees were aware of PREA First

Responder responsibilities in the event of a reported PREA concern. All staff are mandated to receive training annually and the curriculum includes an extensive review of PREA requirements. Training curriculum, training sign-in sheets, and other related training documentation were reviewed by the Auditor. Interviewed staff verified the requirement to acknowledge, in writing, not only that they received PREA training, but that they understood it.

Corrective action: None required

Standard 115.332: Volunteer and contractor training

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

115.332 (a)

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

115.332 (b)

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

115.332 (c)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. Policy GAP 3.41 PREA Compliance
3. Policy 4.05 Code of Conduct
4. GAP Volunteer PREA Acknowledgement
5. GAP Volunteer examples x 5
6. Interviews with the following:
    a. Specialized and Random Staff

Policies, Annual Training 2020 Lesson Plan, and Annual Training 2020 Agenda/Presentation address the mandates of this standard. All contractors and volunteers received the PREA training, including the zero-tolerance policy, reporting, and responding requirements. Due to COVID-19 restrictions there were no volunteers or contractors available for interviews. The training is documented and maintained on file. Copies of training sign-in sheets and other related documents were reviewed by the Auditor.

Corrective action: None required

Standard 115.333: Resident education

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

115.333 (a)

- During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No
- Is this information presented in an age-appropriate fashion? ☒ Yes ☐ No

115.333 (b)

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No
- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents? ☒ Yes ☐ No
- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

115.333 (c)

- Have all residents received such education? ☒ Yes ☐ No

- Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility? ☒ Yes ☐ No

115.333 (d)

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

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

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

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

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

115.333 (e)

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

115.333 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. Local Resources List
3. PREA Brochure
4. Orientation-Intake Documentation
5. PREA Zero Tolerance Poster
6. Resident Intake document
7. Resident Intake Acknowledgement x 5
8. No means No Poster
9. Orientation Checklist/Signature Sheets
10. Resident PREA Handbook
11. Resident PREA Handbook Resident Signatures Acknowledgment x 5
12. Resident Education training dates grid
13. Interviews with the following:
    a. Specialized and Random Staff
    b. Residents

Policies, training curriculum, signed acknowledgements, and Orientation Checklist/Signature Sheets address the mandates of this standard. The facility puts forth its best efforts to educate the residents regarding the PREA. Residents receive information during the intake process including a Resident PREA Handbook, printed in English and Spanish. A staff member conducts an education program regarding the PREA for all residents within 30 days of their arrival at the facility. The program includes definitions of sexually abusive behavior and sexual harassment, prevention strategies, and reporting modalities. There are PREA posters displayed throughout the facility and in each housing unit. These posters offer a "Hotline" telephone number, which may be called to report sexual abuse or sexual harassment. Since the "Hotline" telephone number is an 800-toll-free number, residents are advised that they can contact any staff member to place the call. PREA information is posted in the Resident PREA Handbook and posted in each housing unit for resident correspondence concerning any sexual abuse or sexual harassment allegation. There is also a translation language line available to LEP residents. The Auditor was provided a random sampling of PREA Checklists/Signature Sheets to verify that residents, admitted during the auditing period, received education and relevant written materials. All residents are required to acknowledge, in writing, completion of PREA education. During the interview process, randomly selected residents indicated they received information about the facility's rules against sexual abuse/sexual harassment, when they arrived at the facility. They further indicated they were advised about their right not to be sexually abused/sexually harassed, how to report sexual abuse/sexual harassment, and their right to not be punished for reporting sexual abuse/sexual harassment. Residents were aware of available services outside of the facility for dealing with sexual abuse.

Corrective action: None required

Standard 115.334: Specialized training: Investigations

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

115.334 (a)

- In addition to the general training provided to all employees pursuant to §115.331, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☐ Yes ☐ No ☒ NA

115.334 (b)

- Does this specialized training include: Techniques for interviewing juvenile sexual abuse victims? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☐ Yes ☐ No ☒ NA

- Does this specialized training include: Proper use of Miranda and Garrity warnings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☐ Yes ☐ No ☒ NA

- Does this specialized training include: Sexual abuse evidence collection in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☐ Yes ☐ No ☒ NA

- Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☐ Yes ☐ No ☒ NA

115.334 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☐ Yes ☐ No ☒ NA

115.334 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. Investigator Certifications
3. Policy GAP 01.12.101 Employee Criminal Misconduct
4. Policy GAP 01.12.105 Reporting of Unusual Incidents
5. Policy GAP 01.12.112 Preservation of Physical Evidence
6. Policy GAP 01.12.115 Institutional Investigative Assignments
7. Policy GAP 01.12.120 Reporting of Unusual Incidents
8. Policy GAP 01.12.135 Reporting of Child Abuse and Neglect
9. Interviews with the following:
    a. Specialized and Random Staff

All information of suspected incidents are conducted by the Greenville Sheriff's Department (GSD) and OHAN. The facility does not conduct investigations of any kind. There was one allegation of sexual abuse in the past twelve months. The case was reviewed by the auditor. The case was substantiated and involved a staff member. The staff member was terminated. Any additional prosecution is determined by the GSD.

Standard 115.335: Specialized training: Medical and mental health care

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

115.335 (a)

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

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

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

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

115.335 (b)

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

115.335 (c)

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

115.335 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? ☒ Yes ☐ No

- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire

2. Memorandum of Understanding (MOU) with Prisma Health System (PHS)
3. Email Correspondence with Julie Valentine (JVC)
4. PHS Emergency Room internal Policy
5. Interviews with the following:
    a. Specialized and Random Staff

Policies, and Annual Training Lesson Plan. Medical and Mental Health Services are conducted by practitioners in the field. The agency ensures all full and part-time medical and mental health practitioners, have been trained according to the practitioner's status in the organization MOU. All mental health and medical staff have received the required specialized training on victim identification, interviewing, reporting and, clinical intervention. Interviews with medical and mental health staff confirmed awareness of their responsibilities regarding the PREA. All cases requiring the processing of sexual assault evidence collection kits are transported to the PHS where a SANE is available at all times (a SANE at PHS was interviewed and confirmed access to these services). JVC is contacted from PHS. A review of the training documentation and policy confirm compliance to this standard.

Corrective action: None required

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.341: Screening for risk of victimization and abusiveness

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

115.341 (a)

- Within 72 hours of the resident's arrival at the facility, does the agency obtain and use information about each resident's personal history and behavior to reduce risk of sexual abuse by or upon a resident? ☒ Yes ☐ No

- Does the agency also obtain this information periodically throughout a resident's confinement? ☒ Yes ☐ No

115.341 (b)

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

115.341 (c)

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Prior sexual victimization or abusiveness? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Current charges and offense history? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Age? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Level of emotional and cognitive development? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical size and stature? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Mental illness or mental disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Intellectual or developmental disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: The resident's own perception of vulnerability? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents? ☒ Yes ☐ No

115.341 (d)

- Is this information ascertained: Through conversations with the resident during the intake process and medical mental health screenings? ☒ Yes ☐ No

- Is this information ascertained: During classification assessments? ☒ Yes ☐ No

- Is this information ascertained: By reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files? ☒ Yes ☐ No

115.341 (e)

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

Auditor Overall Compliance Determination

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Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. Policy 3.41 PREA Compliance
3. Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) screening tool
4. Policy GAP 3.15 Chart Access, Security and HIPAA
5. Policy GAP 3.32 Client Rights and Confidentiality
6. Interviews with the following:
    a. Specialized and Random Staff

Policy addresses the requirements of this standard. Agency and facility policy require the use of a screening instrument to determine proper housing, bed assignment, work assignment, education, and other program assignments, with the goal of keeping residents at a high risk of being sexually abused/sexually harassed separate from those residents who are at a high risk of being sexually abusive. Facility policy also requires all residents be screened within 72 hours of arrival; however, they are routinely screened on the day of arrival. Risk management staff review all relevant pre-sentence documentation and information from other confinement facilities and reassess a resident's risk level, as necessary, within 30 days of his arrival. Agency policy prohibits residents from being disciplined for refusing to answer, or for not disclosing complete information in response to questions regarding their mental/physical health, developmental disability, sexual preferences, sexual victimization history, and perception of vulnerability. Housing and program assignments are made on a case-by-case basis and residents are not placed in housing units based solely on their sexual identification or status. The auditor reviewed five VSAB screening form to ensure compliance. Interviews with risk management staff and a random review of risk screening assessments support the finding that the facility is in compliance with this standard.

Corrective action: None required

Standard 115.342: Use of screening information

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

115.342 (a)

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Housing Assignments? ☒ Yes ☐ No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Bed assignments? ☒ Yes ☐ No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Work Assignments? ☒ Yes ☐ No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Education Assignments? ☒ Yes ☐ No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Program Assignments? ☒ Yes ☐ No

115.342 (b)

- Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged ☒ Yes ☐ No
- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise? ☒ Yes ☐ No
- During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services? ☒ Yes ☐ No
- Do residents in isolation receive daily visits from a medical or mental health care clinician? ☒ Yes ☐ No
- Do residents also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.342 (c)

- Does the agency always refrain from placing: Lesbian, gay, and bisexual residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from placing: Transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from placing: Intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator or likelihood of being sexually abusive? ☒ Yes ☐ No

115.342 (d)

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)? ☒ Yes ☐ No

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

115.342 (e)

- Are placement and programming assignments for each transgender or intersex resident reassessed at least twice each year to review any threats to safety experienced by the resident? ☒ Yes ☐ No

115.342 (f)

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

115.342 (g)

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

115.342 (h)

- If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A for h and i if facility doesn't use isolation?) ☐ Yes ☐ No ☒ NA

- If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A for h and i if facility doesn't use isolation?) ☐ Yes ☐ No ☒ NA

115.342 (i)

- In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. Policy 3.31 One-on-One Room Guidelines
3. Supplemental Explanation documentation
4. Policy 3.41 PREA Compliance
5. Interviews with the following:
    a. Specialized and Random Staff

Policy, documentation, and interviews support compliance with this standard. Agency and facility policy require the use of a screening instrument to determine proper housing, bed assignment, work assignment, education and other program assignments, with the goal of keeping residents at a high risk of being sexually abused/sexually harassed separate from those residents who are at a high risk of being sexually abusive. Housing and program assignments are made on a case-by-case basis and residents are not placed in housing units

based solely on their sexual identification or status. From the information provided by the facility, there were zero resident who self-identified as being bi-sexual, gay, transsexual, or intersex. Additionally, zero residents indicated sexual victimization or abusiveness during risk screening. All residents were interviewed in support of this standard. During the audit, risk management staff indicated transgender and intersex residents would be reassessed monthly and their own views with respect to their own safety are given serious consideration. Additionally, they are given the opportunity to shower separately from other residents. Staff and resident interviews, the review of supporting documentation and the Auditor's observations support the facility being in compliance with the standard. Seclusion is not used at this facility.

Corrective action: None required

REPORTING

Standard 115.351: Resident reporting

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

115.351 (a)

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

115.351 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No
- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No
- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No
- Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment? ☒ Yes ☐ No

115.351 (c)

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

- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.351 (d)

- Does the facility provide residents with access to tools necessary to make a written report? ☒ Yes ☐ No

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

Auditor Overall Compliance Determination

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Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. Department of Social Services (DSS) Memorandum of Understanding (MOU)
3. Policy GA3.29 Staff Boundaries and Reporting Allegations and Neglect
4. Photograph of PREA Box
5. Photograph of PREA Manual
6. Resident PREA Handbook
7. Policy GAP 04.01.302 Sexual Abuse and Harassment - Response Procedures
8. Signage: Sexual Abuse Hotline Number
9. Supplemental Explanation document
10. Risk of Victimzation Screening tool

6. Interviews with the following:
    a. Specialized and Random Staff

d. Residents

Policies, the PREA Notices, and Resident PREA Handbook address the requirements of the standard. A review of supporting documentation and staff/resident interviews indicated that there are multiple ways (verbally, in writing, anonymously, privately and from a third party) for inmates to report sexual abuse/sexual harassment. The facility has procedures in place for staff to document all allegations. There are posters and other documents on display throughout the facility which also explain reporting methods. Each living unit contains a box container with an emergency cell phone and emergency documentation to be used in the event of a PREA incident. All staff members are trained in its location and its use. Staff members promptly accept and document all verbal, written, anonymous, private, and third-party reports of alleged abuse. Family and friends of residents may report sexual abuse/sexual harassment by contacting facility staff, calling the PREA Hotline, or other third party personnel. All interviewed residents confirmed awareness of the multiple methods of reporting sexual abuse/assault allegations. Interviews with staff and residents, observations of posters addressing reporting methods, and an examination of policy/documentation confirm the GAP's compliance with this standard.

Corrective action: None required

Standard 115.352: Exhaustion of administrative remedies

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

115.352 (a)

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

115.352 (b)

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

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

115.352 (c)

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

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

115.352 (d)

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

- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)], does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

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

115.352 (e)

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

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

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

- Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned

upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (f)

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

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

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

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

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

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

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

115.352 (g)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. Policy 3.41 PREA Compliance
3. Policy 3.22 Incident Reports
4. Policy 3.29 Staff Boundaries and Reporting Allegations of Abuse and Neglect
5. Policy 3.36 Resident Grievance Procedures
6. Event Reporting Management Information System (ERMIS)
7. GAP Youth Grievance Response form (DJJ0047)
8. Resident PREA Handbook

4. Interviews with the following:
    a. Specialized and Random Staff
    b. Residents

Policies, and interviews address the requirement of this standard. The policy requires that all PREA grievances be processed in accordance with 115.52a-f. The Office of the Inspector General (OIG) through the Public Safety Section maintains a database containing information on events occurring within any location associated with Department of Juvenile Justice (DJJ). This database is called the Event Reporting Management Information System (ERMIS). The database is compiled through the reports by staff and/or juveniles of events requiring review and/or investigation, and is used to coordinate and ensure timely and appropriate investigation of all pertinent events. Residents may file a grievance, however, all allegations of sexual abuse/sexual harassment, when received by staff, will immediately be referred for investigation. Residents are not required to use an informal grievance process and procedures also allow an resident to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint. Additionally, policy prohibits the investigation of the allegation by either staff alleged to be involved in the incident or any staff who may be under their supervision. Policy states that there is no time frame for filing a grievance relating to sexual abuse or sexual harassment. Allegations of physical abuse by staff shall be referred to local law enforcement and the OIG, in accordance with procedures established for such referrals. Policy addresses the filing of emergency administrative remedy requests. If a resident files the emergency grievance with the institution and believes he is under a substantial risk of imminent sexual abuse, an expedited response is required to be provided within 48 hours. There is no prohibition that limits third parties, including fellow residents, staff members, family members, attorneys, and outside victim advocates in assisting residents in filing requests for grievances relating to allegations of sexual abuse or filing such requests on behalf of residents. There were no grievances filed involving PREA related issues during the past 12 months. There were no grievances alleging sexual abuse that involved an extension

due to the final decision not being reached within 90 days. Additionally, there were no grievances alleging sexual abuse filed by residents in which the resident declined third-party assistance. Residents are held accountable for manipulative behavior and false allegations. Generally, disciplinary action would be taken if a grievance was filed in bad faith.

Corrective action: None required

Standard 115.353: Resident access to outside confidential support services and legal representation

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

115.353 (a)

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

- Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies? ☒ Yes ☐ No

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

115.353 (b)

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

115.353 (c)

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

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

115.353 (d)

- Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation? ☒ Yes ☐ No

- Does the facility provide residents with reasonable access to parents or legal guardians? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. MOU attempt with the Julie Valentine Center (JVC)
3. Youth 3.32 Client Rights and Confidentiality
4. MOU with Prisma Health ER internal Policy
5. MOU with Greater Greenville Mental Health Center
6. MOU with Fairview Family Practice
7. Risk of Victimzation Screening tool
8. Interviews with the following:
    a. Specialized and Random Staff
    b. Residents

Policies and the Resident PREA Handbook address the requirements of this standard. The facility has reached out with a local victim advocacy group and are in negotiations with them to reach a formal MOU. Presently, JVC does provide these services to the facility. The Auditor reviewed the MOU correspondence and scheduled meeting dates. The Resident PREA Handbook provides the contact information for alternate services and the information is also posted in the housing units. Psychology Services staff members have all received victim advocacy support training. the facility also has two MOU's with Mental Health Agencies to provide services to the residents.

Corrective action: None required

Standard 115.354: Third-party reporting

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

115.354 (a)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. PREA Poster
3. Resident PREA Handbook
4. PREA Refresher #8
5. Website https//:generationsgroup/resources-2/
6. Interviews with the following:
    a. Specialized and Random Staff
    b. Residents

Policies, Parent Handbook, PREA Posters, PREA Brochure, and Child Abuse Hotline number meet the mandates of this standard. The posters and telephone numbers and the Website https://generationsgroup/resources-2/ assist third party reporters to report allegations of sexual abuse/sexual harassment. The residents interviewed indicated they were aware of third party reporting and would probably feel more comfortable reporting an incident of sexual abuse to someone inside the facility. Calls to toll-free telephone numbers must be coordinated with a

member of the unit team. GAP maintains two Hotline numbers for residents and staff to use to report. PREA posters are located in visitation areas for family members.

Corrective action: None required

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.361: Staff and agency reporting duties

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

115.361 (a)

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

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

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

115.361 (b)

- Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws? ☒ Yes ☐ No

115.361 (c)

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

115.361 (d)

- Are medical and mental health practitioners required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws? ☒ Yes ☐ No

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

115.361 (e)

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office? ☒ Yes ☐ No

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified? ☒ Yes ☐ No

- If the alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? (N/A if the alleged victim is not under the guardianship of the child welfare system.) ☒ Yes ☐ No ☐ NA

- If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation? ☒ Yes ☐ No

115.361 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. Critical Incident Form
3. Policy 3.22 Incident Reports

4. Policy 3.29 Staff Boundaries and Reporting Allegations of Abuse and Neglect
5. Event Reporting Management Information System (ERMIS)
6. Policy 3.38 ERMIS Reporting
7. DJJ ERMIS Form
8. DJJ Required Event Reporting Grid
9. Interviews with the following:
    a. Specialized and Random Staff
    c. Residents

Policies and interviews address the requirements of this standard. Staff, contractors and volunteers must report and respond to allegations of sexually abusive behavior, regardless of the source of the report. Staff members interviewed were aware of their duty to immediately report all allegations of sexual abuse, sexual harassment and retaliation relevant to the PREA standards. The reporting is ordinarily made to a shift supervisor, but could be made privately or to a third party. Policy requires the information concerning the identity of the alleged resident victim and the specific facts of the case be shared with staff on a need-to-know basis, due to their involvement with the victim's welfare and/or the investigation of the incident. All incidents are entered into a electronic database, Event Reporting Management Information System (ERMIS) with the South Carolina Department of Juvenile Justice. This information is acted upon immediately. A review of policy and interviews with staff support finding the facility is in compliance with this standard. If a juvenile was determined to be at risk of sexual victimization, staff could temporarily place him in another unit. There have been no residents placed in another unit due to a risk of sexual victimization during the past twelve months. This was verified through interviews with random staff. Safety plans would be established to ensure that the resident was safe.

Corrective action: None required

Standard 115.362: Agency protection duties

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

115.362 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. Policy 1.23 Grievance Policy
3. Policy 1.38 Employee Protection (Whistleblower) Policy
4. Policy 3.29 Staff Boundaries and Reporting Allegations of Abuse and Neglect
5. Policy 3.41 PREA Compliance
6. Interviews with the following:
    a. Specialized and Random Staff

Policy and interviews address the requirements of this standard. Staff members interviewed were aware of their duties and responsibilities when they become aware or suspect that a resident is being sexually abused or sexually harassed. All staff indicated they would act immediately to protect the resident, including separating the victim/predator, securing the scene to protect possible evidence, preventing the destruction of potential evidence, and contacting the shift supervisor. In the past 12 months, there were no instances in which the GAP staff determined that an resident was subject to a substantial risk of imminent sexual abuse. There have been no residents placed in this status in the past twelve months. This was also verified through interviews with random staff. Safety plans would be established to ensure that the resident was safe.

Corrective action: None required

Standard 115.363: Reporting to other confinement facilities

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

115.363 (a)

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

- Does the head of the facility that received the allegation also notify the appropriate investigative agency? ☒ Yes ☐ No

115.363 (b)

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

115.363 (c)

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

115.363 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. Policy 3.22 Incident Reports
3. Policy 3.38 ERMIS Reporting
4. Interviews with the following:
    a. Specialized and Random Staff

Policy addresses the requirements of this standard. Policy requires that any resident allegation of sexual abuse occurring while confined at another facility be reported to the Director where the alleged abuse occurred within 72 hours of receipt of the allegation. Established procedures require the Director to immediately notify the other confinement facility, in writing, of the nature of the sexual abuse allegation.

Corrective action: None required

Standard 115.364: Staff first responder duties

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

115.364 (a)

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

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

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

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

115.364 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. PREA Refresher #9 - First Responder Duties
3. PREA Training Quiz
4. Interviews with the following:
    a. Specialized and Random Staff

Policies and interviews address the requirements of this standard. All staff members interviewed were extremely knowledgeable concerning their first responder duties and responsibilities upon learning of an allegation of sexual abuse/sexual harassment. Staff indicated they would separate the residents, secure the scene, prevent the destruction of any evidence, and contact their supervisor and medical staff. The supervisor would continue to protect the resident and notify medical, mental health, and administrative/executive staff. In the past 12 months, there were no allegations that an resident was sexually abused and a first responder was required to separate the victim and the abuser.

Corrective action: None required

Standard 115.365: Coordinated response

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

115.365 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. Policy 3.41 PREA Compliance
3. PREA Training Quiz
4. Interviews with the following:
    a. Specialized and Random Staff

Policy addresses the requirements of this standard. The local policy specifies the guidelines and procedures that prevent sexual abuse/sexual assault and provides for prompt and effective intervention in the event abuse or assault occurs. Local policy also includes procedures for the investigation, discipline and prosecution of the assailant or abuser. The policy details first responder duties, reporting procedures, physical evidence collection/preservation, and medical/mental health care responsibilities. The plan was developed to assist staff in responding to allegations of prohibited and/or illegal sexually abusive behavior.

Corrective action: None required

Standard 115.366: Preservation of ability to protect residents from contact with abusers

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

115.366 (a)

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

115.366 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

The facility does not use a collective bargaining agreement.

Corrective action: None required

Standard 115.367: Agency protection against retaliation

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

115.367 (a)

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

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

115.367 (b)

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

115.367 (c)

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

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

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

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

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

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

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

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

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

115.367 (d)

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

115.367 (e)

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

115.367 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. Policy 1.38 Employee Protection (Whistleblower)
3. Interviews with the following:
    a. Specialized Staff

Policy addresses the requirement of this standard. The policy prohibits any type of retaliation against any staff person or resident who reports sexual abuse/sexual harassment or cooperates in related investigations. The PCM is responsible for monitoring retaliation. During the interview, she indicated that she follows up on all 30, 60 and 90-day reviews to ensure policy is being enforced and conducts periodic status checks on the frequency of incident reports, housing reassignments, and negative performance reviews/staff job reassignments, as required in 115.67c. In the event of possible retaliation, the PCM indicated she would monitor the situation indefinitely. There have been no incidents of retaliation in the past 12 months. Compliance with this standard was determined by a review of policy/documentation and staff interviews.

Corrective action: None required

Standard 115.368: Post-allegation protective custody

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

115.368 (a)

- Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. Policy 3.41 PREA Compliance
4. Interviews with the following:
    a. Specialized Staff

Policy addresses the requirements of the standard. Policy requires staff to assess and consider all appropriate alternatives for safeguarding alleged victims of sexual abuse/sexual harassment. The facility does not use seclusion as placement after allegations. Residents or staff may be re-assigned to another unit or building pending the outcome of the investigation. Compliance with this standard was determined by a review of policy, as well as a tour of the facility and staff interviews.

Corrective action: None required

INVESTIGATIONS

Standard 115.371: Criminal and administrative agency investigations

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

115.371 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] ☐ Yes ☐ No ☒ NA

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).]
  ☐ Yes ☐ No ☒ NA

115.371 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334? ☒ Yes ☐ No

115.371 (c)

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

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

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

115.371 (d)

- Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation? ☒ Yes ☐ No

115.371 (e)

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

115.371 (f)

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

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

115.371 (g)

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

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

115.371 (h)

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

115.371 (i)

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

115.371 (j)

- Does the agency retain all written reports referenced in 115.371(g) and (h) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention? ☒ Yes ☐ No

115.371 (k)

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

115.371 (l)

- Auditor is not required to audit this provision.

115.371 (m)

- When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. Policy 3.29 Staff Boundaries and Reporting Allegations of Abuse and Neglect
3. Policy 3.41 PREA Compliance
4. Interviews with the following:
    a. Specialized and Random Staff

Policies address the components of this standard. According to the Director, the facility fully cooperates with any outside agency that initiates an investigation. The Director serves as the facility liaison and provides requested information to outside investigative agencies, as well as access to the resident. The credibility of an alleged victim, suspect or witness is assessed on an individual basis and is not determined by the person's status as resident or staff. The agency does not require an resident who alleges sexual abuse to submit to a polygraph examination or other truth assessment device as a condition for proceeding with the investigation. During the last 12 months, there was one allegation of sexual abuse/sexual harassment. Local law enforcement conducts all criminal investigations. All allegations are reported to Out of Home Abuse and Neglect (OHAN), Department of Juvenile Justice (DJJ), and the Department of Social Services (DSS) via ERMIS. Compliance with this standard was determined by a review of policy/documentation, and staff interviews.

Corrective action: None required

Standard 115.372: Evidentiary standard for administrative investigations

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

115.372 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. Policy 3.29 Staff Boundaries and Reporting Allegations of Abuse and Neglect
3. Interviews with the following:

Policy addresses the requirement of this standard. The evidence standard is a preponderance of the evidence in determining whether allegations of sexual abuse/sexual harassment are substantiated. The facility does not conduct investigations.

Standard 115.373: Reporting to residents

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

115.373 (a)

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

115.373 (b)

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

115.373 (c)

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

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

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

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

115.373 (d)

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

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

115.373 (e)

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

115.373 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. GAP Investigations Log

3. Interviews with the following:
   a. Specialized and Random Staff

Policy and interviews address the components of this standard. During the last 12 months there has been one allegation of sexual abuse and/or sexual harassment. The facility uses the local law enforcement and OHAN for all criminal investigative services. All allegations are reported to Out of Home Abuse and Neglect (OHAN), Department of Juvenile Justice (DJJ), and the Department of Social Services (DSS). Residents are informed of the investigative process. All investigative decisions require a written response, including the rationale for the decision. This written documentation is made available to youth and/or family member. Copies of all investigative decisions are maintained. Decisions are available to the victim's family, administration, and the DJJ.

Corrective action: None required

DISCIPLINE

Standard 115.376: Disciplinary sanctions for staff

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

115.376 (a)

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

115.376 (b)

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

115.376 (c)

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

115.376 (d)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. Policy 1.13 Conduct and Work Rules
3. Policy 3.29 Staff Boundaries and Reporting Allegations of Abuse and Neglect
4. Interviews with the following:
    a. Specialized and Random Staff

Policies address the requirements of this standard. Employees are subject to disciplinary sanctions for violating agency sexual abuse or sexual harassment policies. There was one reported case of a resident engaging in sexual activity with staff during the past 12 months. This staff member was terminated for violation of agency policy. All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff that would have been terminated if not for their resignation, may be reported to criminal investigators and to any law enforcement or relevant professional/certifying/licensing agencies by the facility, unless the activity was clearly not criminal. Compliance with this standard was determined by a review of policy/documentation and staff interviews.

Corrective action: None required

Standard 115.377: Corrective action for contractors and volunteers

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

115.377 (a)

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

115.377 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. Policy 4.05 Code of Conduct
3. Interviews with the following:
    a. Specialized and Random Staff

Policy addresses the requirements of the standard. Any contractor or volunteer who engages in sexual abuse/sexual harassment is prohibited from contact with residents and is reported to the appropriate investigating agency, law enforcement, or relevant professional/licensing/certifying bodies, unless the activity was clearly not criminal in nature. In non-criminal cases, GAP would take appropriate remedial measures and consider whether to prohibit further contact with residents. During the past 12 months, there were no incidents

where a contractor or volunteer was accused or found guilty of sexual abuse or sexual harassment. Compliance with this standard was determined by a review of policy and volunteer/contractor training files and volunteer/contractor and staff interviews.

Corrective action: None required

Standard 115.378: Interventions and disciplinary sanctions for residents

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

115.378 (a)

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

115.378 (b)

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

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.378 (c)

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

115.378 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions? ☒ Yes ☐ No

- If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education? ☒ Yes ☐ No

115.378 (e)

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

115.378 (f)

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

115.378 (g)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. Policy 3.41 PREA Compliance
3. Resident PREA Handbook
4. Interviews with the following:
    a. Specialized and Random Staff

Policy addresses the components of this standard. Appropriate measures must be taken to protect the due process rights of residents who are, or who may be, subject to discipline. This policy ensures residents are treated fairly under a consistent system of discipline that teaches and encourages appropriate behaviors, and discourages inappropriate behaviors. The Resident PREA Handbook packet addresses all disciplinary sanctions for juvenile residents. The facility does not use seclusion in cases of alleged sexual abuse or harassment. Consensual sex of any nature is prohibited. Residents that sexually abuse or harass staff will be disciplined. The GAP program does not discipline residents who make an allegation in good faith, even if an investigation does not establish evidence sufficient to substantiate the allegation.

Corrective action: None required

MEDICAL AND MENTAL CARE

Standard 115.381: Medical and mental health screenings; history of sexual abuse

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

115.381 (a)

- If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (b)

- If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (c)

- Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law? ☒ Yes ☐ No

115.381 (d)

- Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. GAP Medical Care Procedures
3. GAP Risk of Victimzation Screening Tool
4. Interviews with the following:
    a. Specialized and Random Staff
    b. Residents

The procedures implemented at the facility addresses the requirements of this standard. At the point of entry, the Program Director assesses the resident for any medical concerns. During the intake process, assessment includes the resident's and families' medical history, immunization records, allergies, operations, injuries and illnesses. Within 72 hours of admission the resident, is transported to a physician for a complete physical, including a hearing, dental and vision screening and a TB test. The Scheduling Assistant is responsible for making the appointment and transporting the resident to each appointment. Once an appointment is made, the Scheduling Assistant informs the assigned HSP, who generates a medical consult form. The Scheduling Assistant is responsible for recording comments and recommendations from the doctor and obtaining signatures when applicable. On the day of the appointment, the Scheduling Assistant is responsible for immediately relaying the information and consult form to the assigned HSP. In the event that a prescription is prescribed, the Scheduling Assistant will have it filled at the local pharmacy. Long term prescriptions will be faxed to White Oak Pharmacy by the Scheduling Assistant or Human Services Professional (HSP). All prescriptions are recorded on a medication administration record (MAR) by the HSP. Based on the initial physical results, hearing, dental and vision assessments, appointments are made within thirty days of a resident's arrival.

In the past 12 months, 100% of residents who disclosed prior victimization during screening were offered a follow up meeting with a medical or mental health practitioner. Additionally, 100% of the residents who have previously perpetrated sexual abuse, as indicated during the screening, were offered a follow up meeting with a mental health practitioner. Treatment services are offered without financial cost to the inmate, as confirmed by observation and a review of intake screening documents. Screening for prior sexual victimization in any setting is conducted by unit team staff during in-processing procedures. In-processing procedures also include screening for previous sexually abusive behavior in an institutional setting or in the community. When indicated, staff members ensure that the resident is offered a follow up meeting with a mental health practitioner within 14 days of the intake screening. Information related to sexual victimization or abusiveness is limited to medical and mental health practitioners and other staff with a need-to-know for the purpose of determining treatment plans, security, housing, work, program assignments and other management decisions. Signed and dated informed consents are obtained from residents before reporting prior sexual victimization which did not occur in an institutional setting. All information is handled confidentially. Interviews with the intake screening staff support a finding that the facility is in compliance with this standard.

Corrective action: None required

Standard 115.382: Access to emergency medical and mental health services

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

115.382 (a)

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

115.382 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362? ☒ Yes ☐ No

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

115.382 (c)

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

115.382 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. GAP Medical Care Procedures
3. MOU correspondence with JVC
4. MOU with Prisma Health System
5. Interviews with the following:
   a. Specialized and Random Staff

The procedures implemented at the facility addresses the requirements of this standard. All services are provided to residents at no cost. The facility provides timely, unimpeded access to free emergency medical and crisis intervention providers. Referrals are made to Prisma Health System and the Julie Valentine Center.

Corrective action: None required

Standard 115.383: Ongoing medical and mental health care for sexual abuse victims and abusers

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

115.383 (a)

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

115.383 (b)

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

115.383 (c)

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

115.383 (d)

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

115.383 (e)

- If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.) ☐ Yes ☐ No ☒ NA

115.383 (f)

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

115.383 (g)

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

115.383 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. GAP Medical Care Procedures
3. MOU correspondence with JVC
4. MOU with Prisma Health Center
5. Event Reporting Management Information System (ERMIS)
6. Interviews with the following:
    a. Specialized and Random Staff

The procedures implemented at the facility addresses the requirements of this standard. The facility medical and mental health services are provided by outside services. Medical personnel are available for consultation or call-back on off-duty hours. Mental health providers are also available for call-back during off-duty hours. Information and access to care is offered to all resident victims, as clinically indicated. Victim advocacy services are offered through trained staff members and the JVC. Agency policy prohibits resident co-pays for medical treatment in cases of sexual abuse. All treatment is offered at no financial cost to the resident. Resident victims of sexual abuse are offered information about, and timely access to sexually transmitted infection prophylaxis. This information is provided in accordance with professionally accepted standards of care, when medically appropriate. There were no allegations of sexual abuse that required referral for forensic evidence collection by a SAFE/SANE provider in the past year. Compliance with this standard was determined by a review of policy/documentation and interviews with a SANE and facility staff. ERMIS was also reviewed. Secondary materials documenting compliance are on file.

Corrective action: None required

DATA COLLECTION AND REVIEW

Standard 115.386: Sexual abuse incident reviews

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

115.386 (a)

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

115.386 (b)

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

115.386 (c)

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

115.386 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.386 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. Policy 3.41 PREA Policy
3. Event Reporting Management Information System (ERMIS)
4. GAP Investigations Log
5. Interviews with the following:
    a. Director

Policy addresses the requirements of this standard. Administrative and criminal investigations are completed on all allegations of sexual abuse/sexual harassment. Local law enforcement conducts all criminal investigations. The GAP conducts a sexual abuse incident review at the conclusion of every sexual abuse investigation, unless the allegation was proven to be unfounded. Based on interviews with members of the facility incident review team, the review is conducted within 30 days of the conclusion of the investigation and consideration is given as to whether the incident was motivated by race, ethnicity, gender identity, status, perceived status, or gang affiliation. The team also makes a determination as to whether additional monitoring technology would be added to enhance staff supervision. The review team is comprised of upper-level management officials, including the Director, PCM, and the HSP. Per policy, all required reviews by the team are completed within 30 days of the conclusion of all investigations. Per policy, the findings are thoroughly documented. An annual review of all incidents is also completed. All information is posted into ERMIS. The review team seeks additional information from other staff, as needed, to ensure a thorough review has been completed.

Corrective action: None required

Standard 115.387: Data collection

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

115.387 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? ☒ Yes ☐ No

115.387 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually? ☒ Yes ☐ No

115.387 (c)

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? ☒ Yes ☐ No

115.387 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews? ☒ Yes ☐ No

115.387 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) ☒ Yes ☐ No ☐ NA

115.387 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. US Census GAP 2017
3. Review of Event Reporting Management Information System (ERMIS)
4. Interviews with the following:
    a. Director
    b. Incident Review Team Member

The procedures implemented at the facility addresses the requirements of this standard. The data collected includes the information necessary to answer all questions from the most recent version of the Survey of Sexual Violence, conducted by the Department of Justice. GAP aggregate incident-based sexual abuse data annually. Upon request GAP provides all data from the previous calendar year to the Department of Justice. The agency aggregates and reviews all data annually. All Data is collected into the South Carolina Department of Juvenile Justice ERMIS system

Corrective action: None required

Standard 115.388: Data review for corrective action

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

115.388 (a)

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

115.388 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse ☒ Yes ☐ No

115.388 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.388 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
4. Interviews with the following:
   a. Director

Policy addresses the requirements of this standard. As confirmed by a review of supporting documentation, the GAP collects accurate, uniform data for every allegation of sexual abuse/sexual harassment by using a standardized instrument. The agency tracks information concerning sexual abuse via the Event Reporting Management Information System (ERMIS). The data collected includes the information necessary to answer all questions from the most recent version of the Survey of Sexual Violence, conducted by the SCDJJ. The report includes a comparison of the current year's data and corrective actions with those prior years and provides an assessment of the agency's progress. The agency aggregates and reviews all data annually.

Corrective action: None required

Standard 115.389: Data storage, publication, and destruction

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

115.389 (a)

- Does the agency ensure that data collected pursuant to § 115.387 are securely retained? ☒ Yes ☐ No

115.389 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.389 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

115.389 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. GAP Pre-Audit Questionnaire
2. Policy GAP 04.01.301 Sexual Abuse and Harassment and Intervention Program
3. Policy GAP 01.05.105 Use of Computers
4. Event Reporting Management Information System (ERMIS)

4. South Carolina Department of Juvenile Justice (SCDJJ) Website: www.djj.sc.gov
5. Interviews with the following:
    a. FD

Policies address the components of this standard. GAP maintains sexual abuse data collected for at least ten years after the date of its' initial collection. GAP monitors and makes available aggregated sexual abuse data from its' facilities and contracted agency facilities on its' website. That data can be found at www.djj.sc.gov. All personal identifiers are removed before posting information.

Corrective action: None required

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

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

115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*) ☒ Yes ☐ No

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard.*) ☒ Yes ☐ No

- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? ☒ Yes ☐ No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? ☒ Yes ☐ No

115.401 (m)

- Was the auditor permitted to conduct private interviews with residents, residents, and detainees? ☒ Yes ☐ No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

This was the first PREA audit of this facility. The Auditor was allowed access to all areas of the facility and had access to all required supporting documentation. The Auditor was able to conduct private interviews with both residents and staff. All GAP facilities have received at least one PREA audit since August 20, 2012. At least one-third of all agency facilities were audited during the one-year period after August 20, 2012. The Auditor was provided supporting documentation before and during the audit. Notifications of the audit posted throughout the GAP allowed residents to correspond confidentially with the Auditor prior to the audit. No confidential correspondence was received by the Auditor as a result of the audit postings at the facility.

Corrective action: None required

Standard 115.403: Audit contents and findings

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

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The GAP has fully implemented all policies, practices and procedures outlined in the PREA standards. The Auditor reviewed applicable standards and, through the review of supporting documentation, interviews with staff, residents, and the observation of physical evidence, concluded that this facility fully meets and substantially complies with the PREA standards for the relevant review period. The GAP policies are directly tied to the PREA standards and staff expectations. The facility's leadership is fully committed to eliminating sexual abuse/sexual harassment, as evidenced in the realistic staffing analysis and the recommendations for enhanced supervision techniques. PREA training for staff and residents is documented and all stakeholders receive the appropriate level of training and are knowledgeable of the intent of the PREA and the tools available to ensure prevention, detection, reporting, and response to sexual abuse incidents. Sexual abuse and victimization propensity screening is well established and tracked in an organized fashion. Referrals for mental health counseling are integrated in the intake and allegations of sexual abuse processes. Medical networks for the residents are established in the community. The public has access to reporting mechanisms and agency PREA trends data via the agency website. The GAP currently complies with all applicable PREA standards and no corrective actions are required.

Corrective action: None required

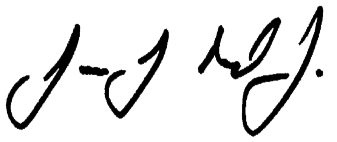
AUDITOR CERTIFICATION

I certify that:

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

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.[1] Auditors are not permitted to submit audit reports that have been scanned.[2] See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.



December 31, 2020

Auditor Signature **Date**

[1] See additional instructions here: https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110 .

[2] See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.