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

☐ **Interim** ☒ **Final**

Date of Report May 25, 2018

Auditor Information

Name: Walter J. Krauss, Psy.D.	**Email:** waltjk@aol.com
Company Name: Click or tap here to enter text.	
Mailing Address: 66 Elaine Drive	**City, State, Zip:** Southbury, CT 06488
Telephone: 860-707-4622	**Date of Facility Visit:** April 9th & 10th, 2018

Agency Information

Name of Agency: Core Services Group, Inc.		**Governing Authority or Parent Agency** *(If Applicable)*: Federal Bureau of Prisons-Residential Reentry Management Office	
Physical Address: 45 Main Street, Suite 711		**City, State, Zip:** Brooklyn, NY 11201	
Mailing Address: Click or tap here to enter text.		**City, State, Zip:** Click or tap here to enter text.	
Telephone: (718) 801-8050		**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: CORE's mission is to empower individuals, families and communities to access and maintain employment, gain independence, and live satisfying and productive lives in communities in which they become contributing and productive citizens.

Agency Website with PREA Information: http://www.coresvcs.org/program-item/residential-reentry-center-and-alternative-to-incarceration-programs-2/

Agency Chief Executive Officer

Name: Jack A. Brown III	**Title:** Chief Executive Officer
Email: jbrown@coresvcs.org	**Telephone:** (718) 801-8050

Agency-Wide PREA Coordinator

Name: Michael Lowe	**Title:** Facility Director
Email: mlowe@coresvcs.org	**Telephone:** (718) 498-0800

PREA Coordinator Reports to:	Number of Compliance Managers who report to the PREA Coordinator
Jack A Brown III	1

Facility Information

Name of Facility:	Brooklyn House Residential Reentry Center			
Physical Address:	104 Gold Street, Brooklyn, NY 11201			
Mailing Address (if different than above):	Click or tap here to enter text.			
Telephone Number:	(718) 498-0800			
The Facility Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit	
☐ Municipal	☐ County	☐ State	☐ Federal	
Facility Type:	☐ Community treatment center	☒ Halfway house	☐ Restitution center	
	☐ Mental health facility	☐ Alcohol or drug rehabilitation center		
	☐ Other community correctional facility			
Facility Mission:	The mission of the Brooklyn House Resident Reentry Center is to provide residents with the necessary tools to enable them to successfully transition to and lead productive lives within their communities.			
Facility Website with PREA Information:	http://coresvcs.org/PREA.pdf			
Have there been any internal or external audits of and/or accreditations by any other organization?	☒ Yes ☐ No			

Director

Name:	Michael Lowe	**Title:**	Facility Director
Email:	mlowe@coresvcs.org	**Telephone:**	(718) 498-0800

Facility PREA Compliance Manager

Name:	Alice Lowe	**Title:**	Training Coordinator & PREA Compliance Mgr
Email:	alowe@coresvcs.org	**Telephone:**	(718) 498-0800

Facility Health Service Administrator

Name:	Click or tap here to enter text.	**Title:**	Click or tap here to enter text.
Email:	Click or tap here to enter text.	**Telephone:**	Click or tap here to enter text.

Facility Characteristics

Designated Facility Capacity: 166	**Current Population of Facility:** 110		
Number of residents admitted to facility during the past 12 months			387
Number of residents admitted to facility during the past 12 months who were transferred from a different community confinement facility:			1
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 30 days or more:			232
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:			256
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:			0
Age Range of Population:	☒ Adults 24-78 years old	☐ Juveniles Click or tap here to enter text.	☐ Youthful residents Click or tap here to enter text.
Average length of stay or time under supervision:			6 months
Facility Security Level:			CCC
Resident Custody Levels:			**Community Correction Component, Pre-Release and Home Detention**
Number of staff currently employed by the facility who may have contact with residents:			39
Number of staff hired by the facility during the past 12 months who may have contact with residents:			31
Number of contracts in the past 12 months for services with contractors who may have contact with residents:			12

Physical Plant

Number of Buildings: 1	**Number of Single Cell Housing Units:** 0
Number of Multiple Occupancy Cell Housing Units:	17 (only 12 currently open)
Number of Open Bay/Dorm Housing Units:	17 (only 12 currently open)

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.):

54 surveillance cameras with two DVR systems with a reported 60 day memory retention

Medical

Type of Medical Facility:	N/A
Forensic sexual assault medical exams are conducted at:	Woodhull Medical and Mental Health Center

Other

Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:	13
Number of investigators the agency currently employs to investigate allegations of sexual abuse:	1

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.

On April 9th & April 10th, 2018 CORE Services Group, Inc.'s, Brooklyn House received an on-site PREA audit by Walter J. Krauss, Psy.D, DOJ Certified PREA Auditor. During the Pre-Audit phase, the auditor reviewed a variety of documentation provided by the agency and facility. These included policies and procedures, plans, protocols, training records, curricula, and other documents related to demonstrating compliance with PREA Standards. In collaboration with the Vice President and Chief Administrative Officer, Dr. Krauss spoke with administration via conference call prior to the site visit to discuss the agenda, answer any questions staff may have, and to provide information on how best to facilitate the on-site auditing process. The auditor provided an agenda for the site visit and requested additional information be made available on the first day of the audit. This additional information included resident rosters with housing unit assignments and staff rosters broken down by job title and shift.

Upon arrival at Brooklyn House, this auditor was immediately impressed with the bright ambient atmosphere and the cleanliness of the facility. Zero tolerance PREA posters in English and Spanish as well as the required announcement indicating this auditor's intent to conduct a formal PREA audit on April 9th through April 10th were posted to the left of the control desk in the main hallway.

The on-site audit began with a meeting that included the PREA Auditor, Vice President & Chief Administrative Officer, Vice President of Operations, Facility Director / PREA Coordinator, Deputy Director of Operations, Training Coordinator / PREA Compliance Manager, and the Quality Assurance Specialist. The discussion focused on the audit process, the interim/final 45-day report, corrective action plan period if required, and the final report. The meeting was followed by a comprehensive tour of the facility.

The tour of the facility was facilitated by the Facility Director / PREA Coordinator. During the tour, it was noted that posters were prominently displayed throughout the facility in both English and Spanish. All areas of the facility were reviewed including the main floor, first floor, and second floor. Brooklyn House has seventeen different housing units/rooms with the capacity designed to accommodate 166 residents. Eight of the eighty nine residents were female, who all live in Room # 001 in a dorm-style setting. The capacity for the men's rooms range from two to eighteen with those designated as being risks for sexual victimization housed in the smaller rooms, in particular the Handicap Unit on the main floor.

Interviewees were randomly selected for both residents and staff by the auditor. At least one resident from each of the twelve open housing units were randomly selected. Twenty two staff were interviewed as well, incorporating all levels of staff and across all three shifts. Thirteen of those staff qualified as random staff interviews. None of the residents spoke Spanish, or any other language, with English as a second language. There were no residents at the facility at the time of the audit who had reported current PREA allegations, reported prior victimization, or were identified as cognitively limited or developmentally disabled. There were two residents who had identified themselves as gay, lesbian, bisexual, transgender, or intersex and there was one resident interviewed that reported an extensive mental health history that was asked additional questions to ensure that the PREA education and information was provided to them appropriately.

Staff interviews at the agency level included Core Services Group's Vice President & Chief Administrative Officer and a Human Resources representative. Phone interviews were conducted with the Bureau of Prisons Residential Reentry Manager; the Senior Director of Emergency Medicine at the Woodhull Medical Center in Brooklyn, NY; and the Director of the Brooklyn Community Program for Safe Horizon. At the facility-level, the Facility Director/PREA Coordinator, Training Coordinator/PREA Compliance Manager, Investigative Specialist, two Caseworkers, Aftercare Counselor, Employment Specialist, eight Guard I, and three Guard II staff. Facility-based staff were asked additional questions as well to meet process requirements, including those questions from the Medical and Mental Health staff (Aftercare Counselor), intake and screening staff (Caseworker), and a staff member who monitors retaliation (Facility Director). There were no staff who had acted as a first responder to a sexual assault and the facility does not utilize volunteers, interns, or contractors who enter the facility with any regularity, but when they do come on-site they are never left alone with the residents unsupervised and are made aware that it is a zero tolerance facility. There was no correspondence sent to the auditor's attention, no allegations of sexual abuse reported at a prior facility outside of the agency, and no reports of sexual abuse or sexual harassment at the Brooklyn House in the past 12 months.

There was one incident that was managed as if it were a PREA incident, involving a staff member and a former resident. The incident reportedly involved an inappropriate friendship that developed between an administrator and a former resident after the resident's release from the program. The incident did not occur on-site and did not include any sexually inappropriate behaviors or harassment reported by either party involved. Upon completion of the investigation, it was determined to be unsubstantiated, no criminal charges were filed, and the administrator resigned. In this auditor's opinion, the incident did not qualify as a PREA incident and administration was encouraged to discuss it with the PREA Resource Center as they were interested in updating the facility annual data such that this incident could be removed from the statistics.

At the end of the on-site visit, an exit conference was held to discuss the findings up to that point. Staff were praised for their efforts and were thanked for their hospitality. Following the on-site visit, this auditor sent two-emails providing feedback and requesting interim corrective action. The first e-mail was relevant to issues needing to be addressed and the second was more specific to the need for policy updates. Most correspondence occurred via e-mail and a

final flash drive was sent to this auditor complete with the corrective actions incorporated. The final report was subsequently submitted and the facility was asked to post the report to their website as required.

All staff interviewed were professional as well as knowledgeable of the agency's zero tolerance policy for sexual abuse and sexual harassment and how it pertained to them. Residents were appropriate and respectful as well. It shall also be noted that the Facility Director / PREA Coordinator and his staff were remarkably responsive to requests and recommendations, and were flexible and professional throughout this process, all in an effort to keep the residents and staff safe and to achieve compliance.

Facility Characteristics

The auditor's description of the audited facility should include details about the facility type, demographics and size of the inmate, 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 CORE Services Group, Inc.'s, Brooklyn House provides a residential community correctional program for offenders who are reintegrating into the community for those who are on supervised release who may need more supervision, as well as those who may need an alternative to incarceration. The mission of the Brooklyn House Resident Reentry Center is to provide residents with the necessary tools to enable them to successfully transition to and lead productive lives within their communities.

This is achieved by providing residents with supportive services, which include but are not limited to, job readiness and employment placement services, needs assessment, referrals to substance abuse and mental health treatment providers, life skills / mentoring, transition skills, Thinking for a Change (T4C), D.E.T.O.U.R. (Dignity, Encouragement, Truthfulness, Optimism, Uniqueness, and Respect), and case management.

Originally built in 1972 and after being used primarily as a daycare facility, CORE Services Group's Brooklyn House opened its doors on September 13, 2012 following a significant renovation designed to meet the needs of the program. A key feature of the renovation was the installation of a state-of-the art surveillance system with fifty four cameras in total. These cameras are monitored from the control desk or by key staff who are authorized to have remote access.

At the time of the on-site visit, there was a total of thirty nine staff at Brooklyn House. The facility utilizes a three shift per day operations system: 1st shift is 12:00 AM to 8:30 AM; 2nd shift is 8:00 AM to 4:30 AM; and 3rd shift is 4:00 AM to 12:30 AM. According to the Facility Director / PREA Coordinator, there is at least one Guard II on every shift and one female and male staff on 1st shift, one female and two males on 2nd shift, and two females and two males on 3rd shift. In addition, the Deputy Director of Operations provides additional coverage on these shifts as needed. Guards conduct roves or tours of the housing areas every two hours during the 1st and 2nd shifts and hourly during the 3rd shift.

The tour included all areas of the facility. On the main floor, one finds the main entrance, control center, dining area which also doubles as a recreation area, kitchen, a wing that includes all the administrative offices, and a room where four kiosks are found through which grievances or e-mails may be sent between 5:30 AM and 11:00 PM daily. Residents are permitted to use their cell phones or facility phones located throughout the facility at any time to access outside victim support services or resources available to them to submit complaints.

The women's dorm-style room is also located on the main floor near the security and administration offices. They have a separate bathroom for the women with toilet stalls and showers with curtains that allow for privacy. The men have a similar set up on the first and second floors with two bathroom/shower areas on each. None of the cameras' field of view includes the bedrooms or the toilet and showers areas. The kitchen and dining area are located on the main floor to the left towards the end of the main hallway upon entrance to the facility. There is access to the roof, but it is off limits to the residents; however, they do have four surveillance cameras covering the roof area as well with a large blind spot behind the area where the electrical equipment is found as already mentioned.

The facility has seventeen different housing units/rooms with the capacity designed to accommodate 166 residents. Eight of the residents are females (eighteen is the max) who all live in Room # 001 in a dorm-style setting. Unless a male resident is assigned to or requires the use of the handicapped room, all male residents are assigned to a room on either the first or second floor. On each of these two floors are large bathroom/shower areas that have three toilets with privacy doors, two urinals with visual shields, and five showers with curtains, all allowing for excellent privacy when they are in use.

The capacity for the men's rooms range from two in a small room to eighteen in an open bay dorm-style set up with those designated as being risks for sexual victimization housed in the smaller rooms, in particular the Handicap Unit on the main floor. If a woman is considered to be at risk, the option to move that individual to another room is more of a challenge because there is only one female room in the facility. If the smaller male room adjacent to the female room is empty or there is someone housed in that room that is not required to be there, the male would potentially be moved upstairs and a woman considered to be at risk could be placed in that smaller room. If a potential or actual conflict develops between two women, the Facility Director / PREA Coordinator indicated it would be likely that Home Detention would be expedited for one of them based on eligibility dates and Federal Bureau of Prisons approval. Ultimately, each situation is taken on a case by case basis. Guards reportedly do "roves" or walk-throughs / tours hourly during waking hours as well as at night. At the time of the on-site audit, Brooklyn House had twenty nine Home Detention residents who do not live in the facility, but must check in once per week. On Day 1 of the on-site audit (4-9-18) there were eighty nine In-House residents (eighty one males and eight women) and the aforementioned twenty nine Home Detention residents.

Within the facility there are a total of fifty five cameras. Although the previous audit report by this auditor indicated there were thirty two cameras, staff indicated during this site visit that there were actually fifty four with another camera added May 10th in the recreation area. Until then, no additional cameras had been added since the initial audit in 2015. The camera surveillance system allows for 50 days of memory and the cameras may be reviewed remotely if authorized. Staff authorized to review the cameras remotely include the Facility Director,

Chief Executive Officer, Vice President & Chief Administrative Officer, Vice President of Operations, Information Technology staff, and the Investigative Specialist. The stairwells allow for excellent video camera surveillance when residents transition between floors and residents are not authorized to access the roof without supervision.

During the tour it was observed that there were four blind spots of concern to this auditor, including the walk-in freezer in the kitchen area, an alcove in the back of Room #202, the area around the electrical unit on the roof, and the back of the recreation area. There is camera surveillance to the front of the walk-in freezer, but not inside; however, the area is restricted and residents cannot be alone in the kitchen area. The issue in Room # 202 is addressed by the roves conducted by staff who walk through that area each time. Four cameras are posted on the roof, but there is a large blind spot behind the area where the electrical equipment is found. Since the tour and the 45-day interim, administration added a camera to address the blind spot in the back of the recreation area.

Summary of Audit Findings

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

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

Number of Standards Exceeded: 1

Click or tap here to enter text.

Number of Standards Met: 40

Click or tap here to enter text.

Number of Standards Not Met: 0

Click or tap here to enter text.

Summary of Corrective Action (if any)

It is clear that the CORE Services Group and the Brooklyn House program have a firm commitment to meeting PREA Standard requirements not only in policy, but in practice as well. This auditor left the on-site visit confident that the residents are safe and have an excellent understanding of what they need to do in the event of sexual harassment or sexual abuse at this facility. Throughout the process, the agency and facility staff interviewed were professional and knowledgeable of the PREA requirements as well as most resources available at the facility level. Administration was responsive to concerns, open to suggestions, and encouraged the auditor to provide feedback on how the facility could improve where applicable. Overall, it was a pleasure to work with the Administration and staff during this process, and this auditor was appreciative of the facility's hospitality and ability to facilitate this process efficiently as requested.

Communication and its value in the effective implementation of the PREA requirements were evident throughout this process via documentation and staff interactions with this auditor. Surveillance camera coverage includes the use of fifty five cameras, which consists of a mix of CNB LBM-20S Monalisa cameras 600 TVL, Cantek VN502VR 600 TVL, and Nuvico CD-HD21N-LI for indoor use. These cameras all have infrared for night vision. The outdoor cameras are CNB LCB-24VFH with IR. DVR retention time is over 50 days.

Despite the use of the aforementioned technology, a significant number of blind spots remain where surveillance is not readily available. These blind spots present additional security challenges, which were shared with Administration. Specific concerns related to blind spots/ surveillance camera coverage included those found in the alcove in the back of Room # 202, the kitchen area near and within the walk-in freezer, the rooftop near the electrical equipment, and in the back of the recreation area. On May 10th, the fifty fifth camera was reportedly installed to address the blind spot in the recreation area.

While there were multiple written policy and minor issues identified during the process in need of corrective action that are addressed within the appropriate Standard description in the next section, the more salient issues will be described in this one.

According to 115.231 (a), all staff are required to receive PREA training, which includes ten basic PREA elements. While it is impressive that the training provided was in depth and was a total of five hours, it was problematic in that staff needed to attend three different trainings on three different days to meet the standard, which is a logistical challenge. As a result, eight of sixteen staff training records reviewed indicated that the required training had not been completed as required. Corrective action included developing a PowerPoint that addresses the ten required elements, providing a list of staff and the dates their training was completed, and a signed attestation that the staff received and understood the training provided. Documentation was provided as requested in response to this auditor's request and the standard was considered to be compliant.

No letters were received from residents in advance of the audit nor were there any residents that reported being sexually assaulted while at the facility during the site visit or within documentation reviewed within the past twelve months. It shall also be noted that when residents were interviewed they did not report any sexual abuse or harassment and they stated that they felt safe at this facility. In addition, most residents offered unsolicited compliments of the staff and program.

Standard 115.241 require that both residents classified as potential high risk for abuse and/or high risk for victimization are identified in order to provide appropriate protections. The objective screening tool and system utilized at the time of the site visit did not specifically classify them in appropriate categories and a system for tracking them had not been developed. None of the eighty nine residents within the facility had been identified as being "High Risk"; however, the facility staff listed ten of the residents as being High Risk despite the tool not identifying any of them as such. Further review of the tool indicated some inconsistencies and concerns. Corrective action recommendations included the development of a method of tracking high risk abusers, initial assessments, thirty day re-assessments, and risk levels as well as either modifying the current tool or working with the PREA Resource Center to identify and implement a recommended tool for the facility to use moving forward.

Administration's response to the identified concerns in Standards 115.241 was impressive. Not only was the spreadsheet developed as requested and initiated, it was completed for all in-house residents by the time the on-site audit had been completed. Furthermore, a new objective screening tool developed by the Indiana Department of Correction was adopted to address the aforementioned concerns. With the development of the new tracking system / spreadsheet and the adoption of an accepted screening tool modified only to account for the thirty day re-assessment requirement, accurate information can now be accessed upon request, high risk residents can be tracked more efficiently, and future PREA audit processes will be simplified.

A majority of staff and most residents were not aware of the staff designated as the PREA Coordinator and PREA Compliance Manager. Administration was asked to provide information to both the residents and staff specifying that Mr. Lowe is the PREA Coordinator and Mrs. Lowe is the PREA Compliance Manager. This should also be included in the PREA information distributed to new residents admitted to the facility. In response, administration wrote a memo to staff and residents to provide them with this information. New admissions will also be provided with a copy of the memo to ensure their awareness.

Ten of thirteen random staff were either unclear or unaware of the Language Line services staff have available to them for resident interpretation services. Upon further review by this auditor, the established service referenced by the facility as the service to use for interpretation was SignTalk; however, those services are specific to hearing impaired residents. As part of the corrective action, the facility was asked to not only identify a resource they can use in the event interpretation services were necessary, but to train staff on its use. In response, administration identified LanguageLine Solutions as the interpretive service provider and staff

were trained in its use as well as SignTalk. Administration was requested to provide the training and training sheets with signatures as verification for each staff to ensure compliance, which they did.

Ten of twelve random residents interviewed and most staff were either unclear or unaware of the services offered by SAFE Horizon, which provides crisis counseling and case management for individuals who have been sexually assaulted. Staff informed this auditor that SAFE Horizon would also provide a victim advocate for any residents who reported sexual assaults and went to Woodhull Medical Center for SAFE or SANE evaluations. When the auditor contacted SAFE Horizon, the Director explained that SAFE Horizon does not provide victim advocate services. Staff were then asked to identify a victim advocate as required and to provide refresher training for residents and staff on the specific services provided by Safe Horizon for the corrective action. In response, administration identified the Deputy Director of Programs as the victim advocate and both staff and residents were informed of the services provided by Safe Horizon.

Residents were not aware whether house phone calls to SAFE Horizon were monitored. Also, it was noted that the PREA posters clearly indicated what departments or organizations to contact in the event resident's wished to report sexual assaults or harassment; however, it was not clear how to contact those resources or what times those resources are available. The corrective action requested included modifications to the PREA posters to provide specific phone numbers and hours of availability and for staff to make it clear to residents that if phone calls are made for such services they can be made at any time and with facility phones that are not monitored. The "Sexual Abuse is a Crime" poster was modified as requested in English and Spanish and key points were documented on a form and signed off by residents to verify compliance that the training was received and understood.

A majority of staff were also unsure of procedures on how to conduct cross-gender and transgender/intersex searches. Administration was asked to provide refresher training and have residents sign off that the training has been received and understood. Administration provided the training sheets with signatures as verification for each staff to ensure compliance.

PREVENTION PLANNING

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

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

115.211 (a)

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

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

115.211 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Brooklyn House has an established and well documented zero tolerance policy. This is evidenced by Policy & Procedure 7.19 *Staff and Resident Rights-Sexual Victimization,* the "Sexual Abuse is a Crime" posters found throughout the facility in English and Spanish, the Visitation Log, and as per all interviews completed with staff and residents.

As indicated, community confinement facilities are required to have only an agency-wide, upper level PREA Coordinator. This requirement is met by Brooklyn House's Facility Director, who serves as the PREA Coordinator. In addition, the Brooklyn House Training Coordinator also serves as the facility-based PREA Compliance Manager. During interviews with each of these two staff, they indicated they do have sufficient time and authority to develop, implement, and oversee agency/facility efforts to comply with the PREA standards. During this audit process, both the auditor and agency administration worked collaboratively to ensure the organizational flow chart clearly indicated both the PREA Coordinator and PREA Compliance Manager. Because the facility has a designated PREA Compliance Manager when only a PREA Coordinator is required, this auditor believes Brooklyn House exceeds the standard requirements.

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

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

115.212 (a)

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

115.212 (b)

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

115.212 (c)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

115.212 (c) stipulates that "Only in emergency circumstances in which all reasonable

attempts to find a private agency or other entity in compliance with the PREA standards have failed, may the agency enter into a contract with an entity that fails to comply with these standards. In such a case, the public agency shall document its unsuccessful attempts to find an entity in compliance with the standards." According to an interview with the CORE Services Group, Inc., Residential Reentry Manager, the agency has not entered into any new contracts since August 20, 2012. He added that the agency has an oversight specialist that would monitor such contracts for compliance, when applicable, and results of contracted facilities submitted and reviewed annually; however, Brooklyn House does not contract with private agencies or other entities for the confinement of residents, so (a) and (b) are not applicable for this standard.

Standard 115.213: Supervision and monitoring

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

115.213 (a)

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

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

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

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

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

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

115.213 (b)

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

115.213 (c)

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

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

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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All elements of this standard are included in Policy & Procedure 7.19.3.10 *Supervision and Monitoring.* A review of rosters and schedules in addition to interviews with the Facility Director / PREA Coordinator and the Training Coordinator / PREA Compliance Manager indicate that the staffing plan did not deviate.

According to the Facility Director / PREA Coordinator, there is at least one Guard II on every shift and one female and male staff on 1st shift, one female and two males on 2nd shift, and two females and two males on 3rd shift. In addition, the Deputy Director of Operations provides additional coverage on these shifts as needed. Guards conduct roves or tours of the housing areas every two hours during the 1st and 2nd shifts and hourly during the 3rd shift. There was always at least one female and one male staff on duty per shift over the course of the past year.

In addition, a key feature of the facility is a state-of-the art surveillance system with fifty five cameras in total. These cameras are monitored from the control desk or by key staff who are authorized to have remote access. Administration provided minutes indicating that annual meetings are held in which staffing plans are reviewed, which also addresses the use of video monitoring surveillance and monitoring technologies.

Standard 115.215: Limits to cross-gender viewing and searches

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

115.215 (a)

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

115.215 (b)

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

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

115.215 (c)

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

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

115.215 (d)

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

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

115.215 (e)

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

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

115.215 (f)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Per Policy & Procedure 7.19.3.5.1 *Limits to Cross Gender Viewing and Searches*, Brooklyn House does not conduct cross-gender strip searches, visual body cavity searches, or pat-down searches, even in exigent circumstances. If a situation calls for a female resident to be searched, staff are trained to contact staff from other departments to conduct the search. If no female staff are available from those departments, staff are instructed to conduct searches with a wand, which involves no physical contact with the resident. As per this standard, facility policy prohibits searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. There was some confusion, however, regarding the searches of transgender and intersex residents. As a result, facility administration was asked to provide additional training to staff to clarify the

procedure. Attendance sheets were provided after the on-site visit. The training curriculum had already been reviewed and was appropriate.

None of the fifty five surveillance cameras allow for staff to view toilet/shower areas and it was clear that staff have integrated the practice of staff announcing their presence when entering housing units for cross-gender residents. This was evident during the tour and confirmed during all staff and resident interviews. Administration was asked to slightly modify policy to be consistent with this standard and state privacy requirements within it. All residents reported they have privacy when changing, showering, or when using the bathroom.

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

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

115.216 (a)

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

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

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

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

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

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

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

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

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

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

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

115.216 (b)

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

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

115.216 (c)

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

Auditor Overall Compliance Determination

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

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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.

Brooklyn House Policy & Procedure 7.19.3.16 *Residents with Disabilities and Residents Who are Limited English Proficient* includes the key elements of this standard. Written materials for effective communication and Language Translation Services documentation was also reviewed in support of standard compliance. No residents at the facility during the time of the on-site visit were identified as needing or reported the need for interpretive services.

Policy states, “Brooklyn House shall 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, limited reading skills, or who are blind or have low vision.”

Ten of thirteen random staff interviewed were either unclear or unaware of the Language Line services staff have available to them for resident interpretation services. Upon further review by this auditor, the established service referenced by the facility to use for general language interpretation was SignTalk; however, it was learned that those services are specific to hearing impaired residents. As part of the corrective action, the facility was asked to not only identify a resource they can use in the event interpretation services were necessary, but to train staff on its use. In response, administration identified LanguageLine Solutions as the interpretive service provider and staff were trained as requested. Administration was requested to provide the training and training sheets with signatures as verification for each staff to ensure compliance, which they did.

Standard 115.217: Hiring and promotion decisions

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

115.217 (a)

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

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

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

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

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

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

115.217 (b)

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

115.217 (c)

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

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

115.217 (d)

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

115.217 (e)

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

115.217 (f)

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

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

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

115.217 (g)

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

115.217 (h)

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

Auditor Overall Compliance Determination

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Policy & Procedure 7.19.3.3 *Staff Hiring, Orientation, Training, and Promotion* includes all the required elements of this standard. The files of the randomly selected staff that were interviewed as a requirement in the process were reviewed. Criminal background checks were completed as required. "PREA New Hire and Promotion Candidate Certification" forms were reviewed and completed for all new hires and staff promotions. An interview with the Training Coordinator / PREA Compliance Manager and Human Resources Representative provided further support of the stated policy and standard practice. The latter described a process where staff are checked in real time and on a continuous basis for new offenses committed so that the agency does not have to wait up to five years to learn of criminal offenses that may have been committed.

Standard 115.218: Upgrades to facilities and technologies

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

115.218 (a)

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

115.218 (b)

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

Auditor Overall Compliance Determination

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This item is "Not Applicable"; however, it shall be noted that Brooklyn House initially opened its doors September 13, 2012 complete with the installation of a state-of-the-art surveillance system. Plans had been developed and established well before the standard's August 20, 2012 cut off period. In separate interviews with the agency's Vice President & Chief Administrative Officer and the Facility Director / PREA Coordinator, both emphasized the agency's commitment to safety. Although the planning process did not specifically state that facility modifications or installation of the surveillance cameras were related to protecting residents from sexual abuse, overall resident safety, which includes protecting residents from sexual abuse, was the primary goal. This auditor recommends that any future plans or efforts specifically state how prospective plans or modifications relate to preventing resident sexual abuse.

RESPONSIVE PLANNING

Standard 115.221: Evidence protocol and forensic medical examinations

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

115.221 (a)

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

115.221 (b)

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

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

115.221 (c)

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

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

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

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

115.221 (d)

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

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

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

115.221 (e)

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

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

115.221 (f)

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

115.221 (g)

- Auditor is not required to audit this provision.

115.221 (h)

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

Auditor Overall Compliance Determination

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Policy 7.19.3.12 *Evidence Protocol and Investigation of Sexual Misconduct*, a Memorandum of Understanding (dated 1-25-18) with Safe Horizon of Brooklyn for advocacy services, and a

pamphlet provided to residents entitled “Making Communities Safer from Sexual Violence” explaining protocol in cases of sexual assault were reviewed. Interviews with the Facility Director / PREA Coordinator, Training Coordinator / PREA Compliance Manager as well as phone conversations with the Woodhull Medical Center’s Senior Director of Emergency Medicine and Safe Horizon’s Director of Community Programs in Brooklyn all provided information in the determination of compliance.

Brooklyn House does not conduct an investigation of sexual misconduct without first receiving the approval of the Contracting Officer’s Technical Representative (COTR). The facility will conduct investigations only to the extent it has been authorized; however, if during an authorized investigation criminal behavior is uncovered, staff are advised to stop what they are doing and refer the case immediately to the appropriate law enforcement agency, i.e. New York Police Department (NYPD). Investigative authorities include, but are not limited to, the Department of Justice, Federal Bureau of Investigation, and US Marshals Service.

The “Brooklyn House PREA Incident Criminal Investigation Guideline” delineates the specific responsibilities expected of not only Brooklyn House, but of the investigating agency in an effort to follow a uniform evidence protocol to maximize the potential for obtaining usable physical evidence. Residents are provided related information through “Making Communities Safer from Sexual Violence” pamphlets. Per interviews with the facility’s Investigation Specialist, Training Coordinator / PREA Compliance Manager, and the Facility Director / PREA Coordinator, facility staff cooperate and provide assistance to those entities at their discretion.

Forensic medical exams, when needed, would be conducted at Woodhull Medical Center in Brooklyn, NY. According to Woodhull’s Senior Director of Emergency Medicine, there is a roster of fifteen SAFE or SANE staff that are used in such situations. These providers are on-call 24/7 and they typically arrive at the medical center within the hour they are contacted. The SAFE / SANE providers typically meet monthly to discuss relevant issues. He reported he is not aware of any Brooklyn House residents that have required or were offered this intervention.

Staff initially reported that SAFE Horizon would provide a victim advocate to accompany residents to or meet with at the medical center, but after reviewing the agreement and speaking directly with the Director of the Brooklyn Community Program for Safe Horizon, it was learned that this was not the case. As a result, corrective action was requested so that a victim advocate would be assigned. Administration assigned the Deputy Director of Programs to serve in that capacity if and when necessary.

Standard 115.222: Policies to ensure referrals of allegations for investigations

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

115.222 (a)

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

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

115.222 (b)

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

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

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

115.222 (c)

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

115.222 (d)

- Auditor is not required to audit this provision.

115.222 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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Brooklyn House's Policy & Procedure 7.19.3.12 *Evidence Protocol and Investigation of Sexual Misconduct* and the "Brooklyn House PREA Incident Criminal Investigation Guideline" was reviewed. Interviews with the Facility Director / PREA Coordinator, Investigative Specialist,

Vice President & Chief Administrative Officer, and PREA Compliance Manager also provided information in the determination of compliance.

The "Brooklyn House PREA Incident Criminal Investigation Guideline" delineates the specific responsibilities expected of not only Brooklyn House, but of the investigating agency in an effort to follow a uniform evidence protocol to maximize the potential for obtaining usable physical evidence. Residents are provided related information through the "Making Communities Safer from Sexual Violence" pamphlet. Per interviews with the facility's Investigation Specialist, Training Coordinator / PREA Compliance Manager, and the Facility Director / PREA Coordinator, facility staff cooperate and provide assistance to those entities at their discretion. The following web address can be used to find this information on the agency website: http://www.coresvcs.org/program-item/residential-reentry-center-and-alternative-to-incarceration-programs-2/

From the above link, the agency's 2017 annual report, entitled "Brooklyn House Reentry Center (RRC) Annual Prison Rape Elimination Act (PREA) Report" is available to the public through the agency website. It indicates no reports of sexual abuse or victimization have been made between 2012 and 2017 at Brooklyn House. Interviews with the agency's Vice President & Chief Administrative Officer and Investigative Staff further confirmed adherence to this policy and practice.

TRAINING AND EDUCATION

Standard 115.231: Employee training

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

115.231 (a)

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in 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? ☒ Yes ☐ No

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

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

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

115.231 (b)

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

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

115.231 (c)

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

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

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

115.231 (d)

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

Auditor Overall Compliance Determination

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☐ **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.

According to 115.231 (a), all staff are required to receive PREA training, which includes the ten basic PREA elements indicated above. While it is impressive that the training provided was in depth and was a total of five hours, it was problematic in that staff needed to attend three different trainings on three different days to meet the standard. This posed a logistical challenge, and, as a result, eight of sixteen staff training records reviewed indicated that the required training had not been completed as required. Corrective action included developing a PowerPoint that addresses the ten required elements, providing a list of staff and the dates their training was completed, and completing a signed attestation that the staff received and understood the training provided. Documentation was provided as requested in response to this auditor's request and the standard was considered to be compliant

Refresher training is provided at least every two years, but according to the random staff interviewed, the Facility Director / PREA Coordinator, the Training Coordinator / PREA Compliance Manager, and training records, PREA topics are a common theme throughout the year. Upon completion of the trainings, staff sign a PREA acknowledgment form indicating that they not only received the training, but understand the content.

Standard 115.232: Volunteer and contractor training

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

115.232 (a)

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

115.232 (b)

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

115.232 (c)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Policy 7.19.3.4 *Volunteers, Interns, and Contractors*, the "Brooklyn House Fact Sheet for Contractors and Volunteers", and signed attestation sheets that verify the volunteers, interns, or contractors understood the PREA training provided were all reviewed and interviews with the Training Coordinator /PREA Compliance Manager were all considered in the determination for standard compliance.

The Training Coordinator / PREA Compliance Manager reported that these individuals are typically here for one brief visit, such as the insurance salesman, exterminator, or for repair services. They are never left with residents unsupervised. Individuals classified in this category receive a copy of the "Brooklyn House Fact Sheet for Contractors and Volunteers" as well as sign in on a sheet that briefly describes the facility's zero tolerance policy for sexual abuse and harassment and directs them on how to report such incidents. Five examples were provided and reviewed. They received the "Brooklyn House Volunteer / Mentor Training", which includes a brief basic PREA training.

Standard 115.233: Resident education

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

115.233 (a)

- During intake, do residents receive information explaining: The agency's zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining: How to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining: Their rights to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No

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

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

115.233 (b)

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

115.233 (c)

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

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

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

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

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

115.233 (d)

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

115.233 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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All residents receive PREA-related education during the intake admission process to inform them of the facility's zero- tolerance policy regarding sexual abuse and sexual harassment, how to report incidents or suspicions of sexual abuse and sexual harassment, their rights to be free from sexual abuse and sexual harassment, and to be free from retaliation. Residents are provided a "Brooklyn House Resident Handbook" which includes current information on how residents may contact outside agencies to report allegations of sexual abuse as well as provide specifics related to the grievance process. Residents sign that they receive education related to PREA, which was confirmed in a random review of documentation and through thirteen random resident interviews. PREA education documentation for all thirteen of the random residents interviewed illustrated that most residents receive the PREA education on the date of their admission and the others within twenty four hours.

If it is determined that a resident has limited reading skills, intake staff will read the written materials to those residents. The auditor requested more specific information be available for staff on how to access interpretive services and SignTalk if and when necessary. Additional training was provided for staff in response to this request and a signed attendance sheet was submitted for verification.

Ten of thirteen random staff were either unclear or unaware of the Language Line services staff have available to them for resident interpretation services. Upon further review by this auditor, the established service referenced by the facility as the service to use for interpretation was SignTalk; however, those services are specific to hearing impaired residents. As part of the corrective action, the facility was asked to not only identify a resource they can use in the event interpretation services were necessary, but to train staff on its use. In response, administration identified LanguageLine Solutions as the interpretive service provider and staff were trained in its use as well as SignTalk. Administration was requested to provide the training and training sheets with signatures as verification for each staff to ensure compliance, which they did.

It was noted that the PREA posters clearly indicated what departments or organizations to contact in the event resident's wished to report sexual assaults or harassment; however, it was not clear how to contact those resources or what times those resources are available. The corrective action requested included modifications to the PREA posters to provide specific phone numbers and hours of availability, and for staff to make it clear to residents that if phone calls are made for such services they can be made at any time and with facility phones that are not monitored. The "Sexual Abuse is a Crime" poster was modified as requested in English

and Spanish and key points were documented on a form and signed off by residents to verify compliance that the training was received and understood.

Residents confirmed and demonstrated excellent awareness and knowledge of the PREA education received. This was confirmed through all resident interviews, including one resident who stated, “We have all been PREA-fied.”

Standard 115.234: Specialized training: Investigations

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

115.234 (a)

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

115.234 (b)

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

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

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

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

115.234 (c)

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

115.234 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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Brooklyn House does not conduct criminal investigations (NYPD) and their role in administrative investigations is limited; however, facility-based staff involvement is possible, but would be at the discretion of the Federal Bureau of Prisons. The facility employs an Investigative Specialist who has received the training developed by the National Institute of Corrections: "Training for Investigators Working in Correctional Settings". The topics covered include specialized training for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral.

Standard 115.235: Specialized training: Medical and mental health care

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

115.235 (a)

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

115.235 (b)

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

115.235 (c)

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

115.235 (d)

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

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

Auditor Overall Compliance Determination

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

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

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Instructions for Overall Compliance Determination Narrative

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Brooklyn House residents receive medical and mental health treatment from various community providers. No medical or mental health services are provided on-site at the facility. As a result, this standard is not applicable to Brooklyn House, but because 'N/A' is not an option, the "Meets Standard" option was selected instead.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.241: Screening for risk of victimization and abusiveness

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

115.241 (a)

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

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

115.241 (b)

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

115.241 (c)

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

115.241 (d)

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

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

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

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

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

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

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

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

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

115.241 (e)

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

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

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

115.241 (f)

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

115.241 (g)

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

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

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

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

115.241 (h)

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

115.241 (i)

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

Auditor Overall Compliance Determination

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

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Brooklyn House Policy & Procedure 7.19.3.7 *Screening for Risk of Victimization* requires that all residents admitted to the facility are assessed at intake screening within 72 hours for their risk of being sexually abused by other residents or sexually abusive toward other residents. All nine criteria required in (d) are addressed in the screening tool for sexual victimization. In assessing a resident's risk of being sexually abusive, prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse are included in the screening tool as well. All twelve random residents and four other residents interviewed received their PREA Screening either on the same date of their arrival or within twenty four hours, which is outstanding. Furthermore, seven of those sixteen residents interviewed stayed for more than thirty days, which means they needed a thirty day re-assessment. All seven were re-assessed within that thirty day period. This data was verified through a review of the documentation.

Standard 115.241 requires that both residents classified as potential high risk for abuse and/or high risk for victimization are identified in order to provide appropriate protections. The objective screening tool and system utilized at the time of the site visit did not specifically classify them in appropriate categories and a system for tracking them had not been developed. None of the eighty nine residents within the facility had been identified as being "High Risk"; however, the facility staff listed ten of the residents as being High Risk despite the

tool not identifying any of them as such. Further review of the tool indicated some inconsistencies and concerns. Corrective action recommendations included the development of a method of tracking high risk abusers, initial assessments, thirty day re-assessments, and risk levels as well as either modifying the current tool or working with the PREA Resource Center to identify and implement a recommended tool for the facility to use moving forward.

Administration's response to the identified concerns in Standards 115.241 was impressive. Not only was the spreadsheet developed as requested and initiated, it was completed for all in-house residents by the time the on-site audit had been completed. Furthermore, a new objective screening tool developed by the Indiana Department of Correction was adopted to address the aforementioned concerns. With the development of the new tracking system / spreadsheet and the adoption of an accepted screening tool modified only to account for the thirty day re-assessment requirement, accurate information can now be accessed upon request, high risk residents can be tracked more efficiently, and future PREA audit processes will be simplified.

Standard 115.242: Use of screening information

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

115.242 (a)

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

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

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

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

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

115.242 (b)

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

115.242 (c)

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the 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

115.242 (d)

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

115.242 (e)

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

115.242 (f)

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

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

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

Auditor Overall Compliance Determination

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

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All key elements of this standard are addressed within Policy & Procedure 7.19.3.8 *Housing Facility Assessment*. Administration was asked to incorporate specific elements in the policy so that it is consistent with this standard, including, but not limited to, ensuring that transgender or intersex residents are given housing or programming assignments on a case by case basis and that such decisions are made with serious consideration given to respect to the individual's own safety.

Documentation on how decisions are made was provided and reviewed. Because there are sixteen male units/rooms, there are more options on how to manage male residents at risk. Staff indicated that if a woman is considered to be at risk, the option to move that individual to another room is more of a challenge because there is only one female room in the facility. If the smaller male room adjacent to the female room is empty or there is someone housed in that room that is not required to be there, the male would potentially be moved upstairs and a woman considered to be at risk could be placed in that smaller room. If a potential or actual conflict develops between two women, the Facility Director / PREA Coordinator indicated it would be likely that Home Detention would be expedited for one of them based on eligibility dates and Federal Bureau of Prisons approval. This option is available for males as well. Ultimately, each situation is taken on a case by case basis.

Multiple interviews were conducted, including the Facility Director / PREA Coordinator, Training Coordinator / PREA Compliance Manager, a Caseworker responsible for risk screening, as well as two gay, lesbian, or bisexual residents, all confirming practice consistent with stated policy. There were no transgender or intersex residents in the facility at the time of the audit and the facility does not have any type of isolation unit or practice. The information obtained from the intake, screening, and assessment process is used to assign residents to an appropriate housing unit to ensure their safety and security.

The objective screening tool and system utilized at the time of the site visit did not specifically classify them in appropriate categories and a system for tracking them had not been maintained from the previous audit. None of the eighty nine residents within the facility had been identified as being "High Risk"; however, the facility staff listed ten of the residents as being High Risk despite the tool not identifying any of them as such. This is problematic because if the facility is tasked with identifying high risk residents in an effort to keep them safe and your screening tool does not do what it is intended to do, then there exists the potential that high risk residents are being missed and victims are being housed with victimizers.

Further review of the tool indicated some additional inconsistencies and concerns, i.e. how some items were weighted in the scoring. Corrective action recommendations included the development of a method of tracking high risk abusers, initial assessments, thirty day re-assessments, and risk levels as well as either modifying the current tool or working with the PREA Resource Center to identify and implement a recommended tool for the facility to use moving forward.

Administration's response to the identified concerns in Standards 115.241 was impressive. Not only was the spreadsheet developed as requested and initiated, it was completed for all in-house residents by the time the on-site audit had been completed. Furthermore, a new objective screening tool developed by the Indiana Department of Correction was adopted to address the aforementioned concerns. With the development of the new tracking system / spreadsheet and the adoption of an accepted screening tool modified only to account for the thirty day re-assessment requirement, accurate information can now be accessed upon request, high risk residents can be tracked more efficiently, and future PREA audit processes will be simplified.

REPORTING

Standard 115.251: Resident reporting

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

115.251 (a)

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

115.251 (b)

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

115.251 (c)

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

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

115.251 (d)

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

Auditor Overall Compliance Determination

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

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During the tour and resident interviews it was confirmed that the facility provides multiple internal ways for residents to privately report sexual abuse and harassment, retaliation, and staff negligence by residents or staff. This was reflected in Policy & Procedure 7.19.3.18 *Resident Reporting*, the "Sexual Abuse is a Crime" poster as well as the "Brooklyn House Resident Handbook".

All residents were aware of the toll free rape crisis hotline number for Safe Horizon provided on the posters posted throughout the facility and provided multiple examples of who to contact in the event there was sexual abuse or sexual harassment, including facility staff, family members, an attorney, the NYPD, or write to the Federal Bureau of Prisons regional office or send an electronic message to staff on the ALERT system. Both residents and staff were aware that staff are required to accept reports of sexual abuse and sexual harassment verbally, in writing, anonymously, and from third parties.

Staff were aware of the need to document any resident allegations of sexual abuse and sexual harassment as well as methods for privately reporting it, including telling the Facility Director / PREA Coordinator or Training Coordinator / PREA Compliance Manager, calling 911, Safe Horizon, CORE Services Group corporate office, or the Federal Bureau of Prisons. The "Brooklyn House Personnel Manual" includes the address for the Department of Justice, Office of the Inspector General, to which staff can report sexual abuse allegations privately.

It was noted that the PREA posters clearly indicated what departments or organizations to contact in the event resident's wished to report sexual assaults or harassment; however, it was not clear how to contact those resources or what times those resources are available. The corrective action requested included modifications to the PREA posters to provide specific phone numbers and hours of availability and for staff to make it clear to residents that if phone calls are made for such services they can be made at any time and with facility phones that are not monitored. The "Sexual Abuse is a Crime" poster was modified as requested in English and Spanish and key points were documented on a form and signed off by residents to verify compliance that the training was received and understood.

Standard 115.252: Exhaustion of administrative remedies

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

115.252 (a)

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

115.252 (b)

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

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

115.252 (c)

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

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

115.252 (d)

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

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

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

115.252 (e)

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

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

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

115.252 (f)

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

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

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

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

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

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

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

115.252 (g)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Brooklyn House Policy & Procedure 7.19.3.19 Exhaustion of Administrative Remedies and the "Brooklyn House Resident Handbook" were reviewed. The Facility Director / PREA Coordinator and Training Coordinator / PREA Compliance Manager were also interviewed to determine compliance with this standard

A resident may file a grievance at any time to bring a problem to staff's attention. Third parties including residents, staff members, family members, attorneys or others shall be permitted to assist a resident in filing requests for administrative remedies relating to sexual abuse and will also be permitted to file such requests on the resident's behalf. If a resident declines to have a request processed on their behalf in situations of alleged sexual abuse, the administration will document the resident's decision.

The agency will ensure that a resident who alleges sexual abuse or harassment may submit a grievance without submitting it to the staff person who is the subject of the complaint. In addition, a grievance should never be referred to the staff person involved in a complaint.

After receipt of an emergency grievance alleging a resident is subject to substantial risk of imminent sexual abuse the facility shall 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, shall provide an initial response within 48 hours, and shall issue a final agency decision within 5 calendar days.

There have been no grievances submitted or allegations of sexual abuse in the past twelve months at Brooklyn House.

Standard 115.253: Resident access to outside confidential support services

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

115.253 (a)

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

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

115.253 (b)

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

115.253 (c)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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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.

Policy 7.19.3.20 *Resident Access to Outside Confidential Supportive Services* and the Safe Horizon MOU were reviewed. Interviews with staff and residents as well as a telephone conversation with the Director of the Brooklyn Community Program for Safe Horizon were also considered in determining compliance with this standard.

On 1-25-18, Brooklyn House entered into a Memorandum of Understanding with Safe Horizons, a community organization that provides emotional support services in response to sexual abuse. Resident interviews confirmed that residents are familiar with the posters and their right to call and make reports.

Most residents and staff, however, were neither aware of the services provided by them nor the fact that house phone calls to SAFE Horizon were not monitored. Corrective action included educating residents on the service provided by Safe Horizon and that phone calls made to SAFE Horizon or other resources can be made at any time and with facility phones, which are not monitored. Key points were documented on a form and signed off by residents to verify compliance that the training was received and understood.

Standard 115.254: Third-party reporting

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

115.254 (a)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy 7.19.3.21 *Third-Party Reporting* and the agency website were reviewed and the Facility Director / PREA Coordinator and Training Director / PREA Compliance Manager interviewed to determine compliance with this standard.

Individuals are publicly informed via the agency website on how to make third party reports by accessing the following link: http://www.coresvcs.org/program-item/residential-reentry-center-and-alternative-to-incarceration-programs-2/. When an individual clicks on the link for "How to Reports Incidents of Sexual Abuse", a list of methods are provided, which is also the same information residents see on the "Sexual Abuse is a Crime" posters found throughout the facility. Methods include calling 911, contacting the Facility Director at Brooklyn House, contact the Corporate Office, contacting the Residential Reentry Manager, or by writing to the Office of the Inspector General/U.S. Department of Justice.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.261: Staff and agency reporting duties

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

115.261 (a)

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

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

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

115.261 (b)

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

115.261 (c)

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

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

115.261 (d)

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

115.261 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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All of the elements of this standard were contained within Policy & Procedure 7.19.3.22 *Staff and CORE Services Group, Inc. Reporting Duties*. Staff interviews confirmed that this practice is not only addressed in training, but continues to be emphasized by administration. Since August 20, 2012, however, there have been no examples in which this standard practice was necessary. Facility policy also requires that all staff are required to report any retaliation against residents or staff who made a report and prohibits the disclosure of information related to a report of sexual abuse, other than to the extent necessary to make treatment, investigation, and other security and management decisions. There are no residents admitted to the facility under the age of 18, so (d) would not apply in part; however, if an alleged victim is considered a vulnerable adult, facility policy and state mandatory reporting laws apply.

Standard 115.262: Agency protection duties

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

115.262 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

This standard is addressed within Brooklyn House Policy & Procedure 7.19.3.22 *Staff and CORE Services Group, Inc., Reporting Duties*. During the past calendar year, there have been no reported or documented examples of residents considered to be subject to substantial risk of imminent sexual abuse. Interviews with all staff confirmed that staff have received training as to how to immediately protect identified residents by immediately separating the resident from the potential risk or alleged perpetrator, notifying their respective supervisor, and documenting the information in an incident report.

Standard 115.263: Reporting to other confinement facilities

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

115.263 (a)

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

115.263 (b)

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

115.263 (c)

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

115.263 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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In the past twelve months, there have been no reported or documented resident allegations of sexual abuse while confined at another facility. Policy & Procedure 7.19.3.*11 Reporting of Sexual Misconduct* requires notification of that prior facility within 72 hours, documentation that such notification has been received, and that the allegation is investigated in accordance with the standards. This policy was confirmed in separate interviews with the Vice President & Chief Administrative Officer and the Facility Director / PREA Coordinator.

Standard 115.264: Staff first responder duties

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

115.264 (a)

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

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

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any

actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

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

115.264 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy & Procedure 7.19.3.12 *Evidence Protocol and Investigation of Sexual Misconduct*, contains all of the elements required by the standard. Although there have been no instances or reports of sexual abuse, interviews with thirteen random staff and a review of documentation confirmed training and awareness of protocol and knowledge of these procedures.

Standard 115.265: Coordinated response

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

115.265 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Brooklyn House has a comprehensive facility-specific institutional plan to coordinate actions taken in response to an incident of sexual abuse, which is delineated in the "Sexual Abuse and Victimization Resource Guide". This was further evident through this auditor's interview with the Facility Director / PREA Coordinator and Vice President & Chief Administrative Officer.

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

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

115.266 (a)

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

115.266 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Brooklyn House has not entered into or renewed 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. This was confirmed in an interview with CORE Services' Vice President & Chief Administrative Officer.

Standard 115.267: Agency protection against retaliation

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

115.267 (a)

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

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

115.267 (b)

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

115.267 (c)

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

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

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

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

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

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

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

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

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

115.267 (d)

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

115.267 (e)

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

115.267 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Brooklyn House Policy & Procedure 7.19.3.22 *Staff and CORE Services Group, Inc., Reporting Duties* is written to protect all residents and staff from retaliation. This policy includes protective measures, follow up, and periodic status checks, as required by the standard.

There have been no incidents of sexual abuse or sexual harassment reported or documented in the past twelve months; therefore, there have been neither related incidents of retaliation nor a need to monitor or follow-up any residents for retaliation. The Facility Director / PREA Coordinator (who is charged with monitoring retaliation), Training Coordinator / PREA Compliance Manager, and the Vice President & Chief Administrative Officer were all interviewed and confirmed their knowledge of and requirements related to this standard.

INVESTIGATIONS

Standard 115.271: Criminal and administrative agency investigations

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

115.271 (a)

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

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

115.271 (b)

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

115.271 (c)

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

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

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

115.271 (d)

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

115.271 (e)

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

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

115.271 (f)

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

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

115.271 (g)

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

115.271 (h)

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

115.271 (i)

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

115.271 (j)

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

115.271 (k)

- Auditor is not required to audit this provision.

115.271 (l)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Brooklyn House Policy & Procedure 7.19.3.12 *Evidence Protocol & Investigation of Sexual Misconduct* incorporates the essential elements of this standard. Although there have been no instances of reported or documented sexual misconduct in the past twelve months, an interview with the Investigative Specialist confirmed knowledge and familiarity with the investigative process as it pertains to this standard. He also received the required specialized training developed by the National Institute of Corrections: "Training for Investigators Working in Correctional Settings". Documentation was provided supporting this claim.

Brooklyn House does not conduct criminal investigations (NYPD) and their role in administrative investigations is limited; however, facility-based staff involvement is possible, but would be at the discretion of the Federal Bureau of Prisons.

Standard 115.272: Evidentiary standard for administrative investigations

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

115.272 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Brooklyn House's Policy & Procedure 7.19.3.12 *Evidence Protocol and Investigation of Sexual Misconduct* states, "The agency shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated." This was evident during the interview with the facility's Investigative Specialist, but needed to be added to the policy as part of the corrective action. There were no applicable investigations, however, conducted in the past twelve months.

Standard 115.273: Reporting to residents

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

115.273 (a)

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

115.273 (b)

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

115.273 (c)

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

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

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

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

115.273 (d)

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

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

115.273 (e)

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

115.273 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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All elements of this standard are included in Brooklyn House's Policy & Procedure 7.19.3.23 *Reporting to Residents*. Although there have been no reported or documented allegations or subsequent investigations in the past twelve months, interviews with the Facility Director / PREA Coordinator and the facility's Investigative Specialist demonstrated their knowledge and understanding regarding this standard's requirements.

There was one incident that was managed as if it were a PREA incident, involving a staff member and a former resident. The incident reportedly involved an inappropriate friendship that developed between an administrator and a former resident after the resident's release from the program. The incident did not occur on-site and did not include any sexually inappropriate behaviors or harassment reported by either party involved. Upon completion of the investigation, it was determined to be unsubstantiated, no criminal charges were filed, and the administrator resigned. In this auditor's opinion, the incident did not qualify as a PREA incident and administration was encouraged to discuss it with the PREA Resource Center as they were interested in updating the facility annual data such that this incident could be removed from the statistics.

DISCIPLINE

Standard 115.276: Disciplinary sanctions for staff

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

115.276 (a)

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

115.276 (b)

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

115.276 (c)

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

115.276 (d)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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All elements of this standard are included in Brooklyn House's Policy & Procedure 7.19.3.24 *Disciplinary Sanctions*. There have been no reported or documented allegations of sexual abuse or disciplinary sanctions for violations of agency policies relating to sexual abuse or harassment in the past twelve months.

As indicated in the previous section, there was one incident that was managed as if it were a PREA incident, involving a staff member and a former resident. The incident reportedly involved an inappropriate friendship that developed between an administrator and a former resident after the resident's release from the program. The incident did not occur on-site and did not include any sexually inappropriate behaviors or harassment reported by either party involved. Upon completion of the investigation, it was determined to be unsubstantiated, no

criminal charges were filed, and the administrator resigned. In this auditor's opinion, the incident did not qualify as a PREA incident and administration was encouraged to discuss it with the PREA Resource Center as they were interested in updating the facility annual data such that this incident could be removed from the statistics.

Standard 115.277: Corrective action for contractors and volunteers

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

115.277 (a)

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

115.277 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Brooklyn House Policy & Procedure 7.19.3.25 *Corrective Action for Contractors and Volunteers* addresses the elements of this standard as required. According to the Facility Director / PREA Coordinator and Training Coordinator / PREA Compliance Manager, there have been no contractors or volunteers who have reportedly engaged in sexual abuse in the past twelve months.

Standard 115.278: Interventions and disciplinary sanctions for residents

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

115.278 (a)

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

115.278 (b)

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

115.278 (c)

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

115.278 (d)

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

115.278 (e)

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

115.278 (f)

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

115.278 (g)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Brooklyn House Policy & Procedure 7.19.3.24 *Disciplinary Sanctions* was reviewed and interviews with the Vice President & Chief Administrative Officer and the Facility Director / PREA Coordinator were conducted to assist in determining compliance with this standard.

Although the facility does not have mental health services on-site, the facility can consider and refer residents to the community provider (Community Treatment Services) to participate in therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for sexual abuse. The agency prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred. In the past twelve months, there have been no instances of reported or documented sexual abuse by residents or staff; therefore, there have been no sanctions levied on residents during this audit period.

MEDICAL AND MENTAL CARE

Standard 115.282: Access to emergency medical and mental health services

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

115.282 (a)

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

115.282 (b)

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

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

115.282 (c)

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

115.282 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Brooklyn House Policy & Procedure 7.19.3.26 *Access to Medical and Mental Health Care for Sexual Abuse Victims and Abusers* and a Memorandum of Understanding with Safe Horizon for advocacy services were reviewed and interviews with the Facility Director / PREA Coordinator, Training Coordinator / PREA Compliance Manager, Woodhull's Senior Director of Emergency Medicine, and the Director of the Brooklyn Community Program for Safe Horizon were all considered in the determination of compliance.

Although there were no resident victims of sexual abuse in the past twelve months, resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services without financial cost to the victim, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment. Victims are offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards or case, where medically appropriate.

According to Woodhull's Senior Director of Emergency Medicine, there is a roster of fifteen SAFE or SANE staff that are used in such situations. These providers are on-call 24/7 and they typically arrive at the medical center within the hour they are contacted. The SAFE /

SANE providers typically meet monthly to discuss relevant issues. He reported he is not aware of any Brooklyn House residents that have required or were offered the intervention.

Staff initially reported that SAFE Horizon would provide a victim advocate to accompany residents to or meet with at the medical center, but after reviewing the agreement and speaking directly with the Director of the Brooklyn Community Program for Safe Horizon, it was learned that this was not the case. As a result, corrective action was requested so that a victim advocate would be assigned. Administration assigned the Deputy Director of Programs to serve in that capacity if and when necessary.

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

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

115.283 (a)

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

115.283 (b)

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

115.283 (c)

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

115.283 (d)

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

115.283 (e)

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

115.283 (f)

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

115.283 (g)

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

115.283 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Brooklyn House Policy & Procedure 7.19.3.26 *Access to Medical and Mental Health Care for Sexual Abuse Victims and Abusers* and a Memorandum of Understanding with Safe Horizon for advocacy services were reviewed and interviews with the Facility Director / PREA Coordinator, Training Coordinator / PREA Compliance Manager, Woodhull's Senior Director of Emergency Medicine, and the Director of the Brooklyn Community Program for Safe Horizon were all considered in the determination of compliance.

There were no incidents of sexual abuse reported in the past twelve months. As a result, there was no evidence of practice; however, all elements of this standard were met in Policy & Procedure 7.19.3.26 *Access to Medical and Mental Health Care for Sexual Abuse Victims and Abusers.* The agency offers medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse. Although medical and mental health care is not provided on-site at Brooklyn House, it may be obtained in the community, including mental health case management services through Safe Horizon, and any sexual abuse related services would be provided at no cost to the victim.

Victims are provided medical and mental health services consistent with the community level of care and are offered tests for sexually transmitted infections as medically appropriate. Treatment services are 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.

DATA COLLECTION AND REVIEW

Standard 115.286: Sexual abuse incident reviews

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

115.286 (a)

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

115.286 (b)

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

115.286 (c)

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

115.286 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.286(d) (1) - (d) (5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.286 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Brooklyn House's Policy & Procedure 7.19.3.15 *Program Evaluation* incorporates all the required elements of this standard. Although there have been no reported or documented allegations or subsequent investigations in the past twelve months that would necessitate the need for a sexual abuse incident review, the review team membership had previously been established to include the Facility Director / PREA Coordinator, Training Coordinator / PREA Compliance Manager, CORE Services' Vice President & Chief Operating Officer, the Supervisor on Duty, and the Investigative Specialist. Interviews with the CORE Service Group, Inc.'s Vice President & Chief Operating Officer, Facility Director / PREA Coordinator, Training Coordinator / PREA Compliance Manager, and Investigative Specialist indicated knowledge and understanding of the team's purpose and goals should it be necessary to convene for that purpose in the future.

There was one incident that was managed as if it were a PREA incident, involving a staff member and a former resident. The incident reportedly involved an inappropriate friendship that developed between an administrator and a former resident after the resident's release from the program. The incident did not occur on-site and did not include any sexually inappropriate behaviors or harassment reported by either party involved. As a result, a sexual abuse incident review was not conducted. Upon completion of the investigation, it was determined to be unsubstantiated, no criminal charges were filed, and the administrator resigned. In this auditor's opinion, the incident did not qualify as a PREA incident and administration was encouraged to discuss it with the PREA Resource Center as they were interested in updating the facility annual data such that this incident could be removed from the statistics.

Standard 115.287: Data collection

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

115.287 (a)

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

115.287 (b)

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

115.287 (c)

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

115.287 (d)

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

115.287 (e)

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

115.287 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

All elements of this standard, with the exception of (e) which is not applicable, are included in Brooklyn House's Policy & Procedure 7.19.3.27 *Data Collection*. Although there have been no reported or documented allegations of sexual abuse in the past twelve months; the agency has a mechanism in place to collect, aggregate, and maintain the data, per standard requirements. The data collection instrument is used to collect the data necessary to answer all questions from the USDOJ Survey of Sexual Violence. The agency's 2017 annual report, entitled "Brooklyn House Reentry Center (RRC) Annual Prison Rape Elimination Act (PREA) Report" is available to the public via the agency website at http://www.coresvcs.org/program-item/residential-reentry-center-and-alternative-to-incarceration-programs-2/ references there have been no reports of sexual abuse or victimization between 2012 and 2017.

Standard 115.288: Data review for corrective action

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

115.288 (a)

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

115.288 (b)

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

115.288 (c)

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

115.288 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Brooklyn House's Policy & Procedure 7.19.3.28 *Data Review for Corrective Action* addresses all the necessary requirements of this standard. Interviews with the agency's Vice President & Chief Administrative Officer and Facility Director/ PREA Coordinator further confirmed adherence to this policy and practice.

The agency's 2017 annual report, entitled "Brooklyn House Reentry Center (RRC) Annual Prison Rape Elimination Act (PREA) Report" is available to the public through the agency website at http://www.coresvcs.org/program-item/residential-reentry-center-and-alternative-to-incarceration-programs-2/ and references that there have been no reports of sexual abuse or victimization between 2012 and 2017. Separate reports for 2012 through 2017 were available upon request.

The agency reviews data collected and aggregated pursuant to 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices and training, including by:

1. Identifying problem areas;
2. Taking corrective action on an on-going basis; and
3. Preparing an annual report of its findings and corrective actions

Standard 115.289: Data storage, publication, and destruction

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

115.289 (a)

- Does the agency ensure that data collected pursuant to § 115.287 are securely retained? ☒ Yes ☐ No

115.289 (b)

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

115.289 (c)

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

115.289 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Brooklyn House's Policy & Procedure 7.19.3.29 *Data Storage, Publication, and Destruction* addresses all the elements of this standard. A review of the agency's website and Interviews with the agency's Facility Director/ PREA Coordinator and Training Coordinator / PREA Compliance Manager confirmed adherence to this policy and practice.

The agency's 2017 annual report, entitled "Brooklyn House Reentry Center (RRC) Annual

Prison Rape Elimination Act (PREA) Report" is available to the public through the agency website at http://www.coresvcs.org/program-item/residential-reentry-center-and-alternative-to-incarceration-programs-2/ and references that there have been no reports of sexual abuse or victimization between 2012 and 2017. Separate reports for 2012 through 2017 were available upon request.

Per policy, data is securely retained and such data shall be retained for 10 years.

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 three-year period starting on August 20, 2013, and during each three-year period thereafter, 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.? (N/A before August 20, 2016.) ☒ Yes ☐ No ☐ NA

115.401 (b)

- During each one-year period starting on August 20, 2013, 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? ☒ Yes ☐ No

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 inmates, 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.

Core Services Group, Inc. currently has only one facility that requires PREA Compliance: Brooklyn House. It was audited initially in April 2015 by this auditor at which time the Brooklyn House was determined to be compliant with the PREA standards. During the on-site visit, this auditor had access to, and the ability to observe, all areas of the facility. The auditor received copies of all requested documentation. All resident and staff interviews were conducted in private rooms. No correspondence was received by the auditor prior to the on-site audit or within the interim prior to completing this report.

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 agency has published on its website the prior Final PREA report conducted in April 2015 and they have been instructed to post the Final PREA report within ninety days of issuance by this auditor.

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.

Walter J. Krauss, Psy.D. May 25, 2018

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.