PREA AUDIT REPORT ☐ Interim ☒ Final
COMMUNITY CONFINEMENT FACILITIES

Date of report: August 24, 2016

Auditor Information			
Auditor name: Daniel M. Engert			
Address: PO Box 256 Barker NY 14012			
Email: Daniel.engert@gmail.com			
Telephone number: 716-998-0932			
Date of facility visit: June 19-21			
Facility Information			
Facility name: Catholic Social Services Residential Re-Entry Center			
Facility physical address: 409-411 Olive Street Scranton PA 18509			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 570-342-1295			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☒ Private not for profit		
Facility type:	☐ Community treatment center ☒ Halfway house ☐ Alcohol or drug rehabilitation center	☐ Community-based confinement facility ☐ Mental health facility ☐ Other	
Name of facility's Chief Executive Officer: Pamela Oravec			
Number of staff assigned to the facility in the last 12 months: 29			
Designed facility capacity: 58			
Current population of facility: 29 have varied levels of confinement depending on their re-entry status ; 16 were on home confinement and not housed at the facility during the audit.			
Facility security levels/inmate custody levels: Minimum			
Age range of the population: 21-60			
Name of PREA Compliance Manager: Paul Gianino	**Title:** Center Supervisor		
Email address: pgianino@cssscranton.org	**Telephone number:** 570-342-1295 ext.211		
Agency Information			
Name of agency: Catholic Diocese of Scranton			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: 517 Fig Street Scranton PA 18509			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 570-209-9200			
Agency Chief Executive Officer			
Name: Pam Oravec	**Title:** Director		
Email address: poravec@cssscranton.org	**Telephone number:** (570) 342-1295, ext. 201		
Agency-Wide PREA Coordinator			
Name: Paul Gianino	**Title:** Center Supervisor		
Email address: pgianino@cssscranton.org	**Telephone number:** 570-342-1295 ext.211		

AUDIT FINDINGS

NARRATIVE

Pre-Audit Activities: The PREA Audit of the Catholic Social Services Residential Reentry Center (CSSRRC) was initiated in February 2015. The Agency's PREA Coordinator began to correspond to discuss goals, objectives and time line. The Auditor went over a PRE-Audit Timeline outlining pre-audit tasks to be completed together by the Agency and the Auditor before June 19. The Notice of the June 19-21, 2016 Audit was posted more than six weeks prior to the audit notifying residents and staff of the methods for them to communicate confidentially with the Auditor prior to and at any time during the audit process. During this pre-audit phase, the Agency completed and submitted to the Auditor its Agency/Facility Questionnaire. The Auditor reviewed the PREA Agency Questionnaire and examined numerous documents on each of the PREA Standards including: policies and procedures, resident and staff incident reports, resident and staff investigations, staffing plans, e-mails, training curriculum, staff training records and certifications, contracts and Memoranda of Agreements with outside agencies and vendors, risk screening instrument, and video monitoring system plan. The Auditor and the Agency had several review communications over the phone and via email before the Audit to respond to the Auditor's questions, to discuss issues needing clarification and to discuss follow-up data requested by the Auditor. The Agency was very responsive to these requests, and additional clarifications, data and explanations were provided to the Auditor usually within 24-48 hours of the Auditor's request. The Auditor completed its initial review of the documentation and prepared a working confidential draft of the Auditor Compliance Tool.

Audit Activities: Catholic Social Services Residential Reentry Center is part of the Catholic Diocese of Scranton, PA. The agency is Catholic based, assisting a person's transition from prison to their respective community. The CSS Scranton facility is a 58 bed (max.) male/female facility that contracts with the Pennsylvania State Department of Correction and the US Bureua of Prisons to house offenders that are finishing the remainder of their mandated sentence in the varied levels of confinement and are employed in the community on a work release status. The facility has a PREA Coordinator who also takes on the responsibilities of the PREA Compliance Manager. On June 19-21 2015 I, Daniel M. Engert, a USDOJ Certified PREA auditor performed an on-site audit of facility. I arrived at the facility and conducted an entrance meeting with the PREA Coordinator and the Facility Director. I was then given a thorough tour of the building.The building consists of four (4) floors with double bed rooms and one bathroom/shower. There is a common "living" type room and a full kitchen on each floor. I received a copy of the headcount sheet for that day. There were 32 residents were on seven day confinement, however none of the residents are confined for 24 hours. Due to 8-12 hour work schedules, there were only 19 residents inside the facility at the time of the audit. Nine residents were report-only and were otherwise on home confinement. These residents did not stay at the facility as a result of their stage of re-entry. The security staff numbers were as follows: 8-4 shift (4);4-12 shift(4);12-8 shift (3). There is one maintenance/cleaning person and no volunteers. I then proceeded to interview residents. I interviewed seven (7) residents including four (4) females and three (3) males representing 33% of the population housed during the visit and representative of each housing unit. There was only one resident (female) who identified as LGBTI and she was interviewed. There were 0 limited English-speaking residents on the day(s) of the audit. I interviewed the Agency Director, the PREA Coordinator and six (6) staff members representing approximately 30% of the staff. There are no specialized staff as the agency does not conduct administrative or investigative investigations and there are no medical or mental health staff in this facility. There have been 0 incidents or allegations of staff/resident Sexual Abuse/Harassment and or resident/resident Sexual Abuse/Harassment in the facility within the last 12 months.

Corrective Action Plan: Five standards were determined by the Auditor to be non-compliant. Standards 115.265; 115.266; 115.267; 115.286 and 115.288 required further attention by the facility. The Corrective Action Period was closed on August 24, 2016 upon the Auditor's finding of compliance with each previously identified standard. The final report was issued to the facility.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Center has been in operation in downtown Scranton for over 25 years; they are accredited by the American Correctional Association and have maintained their standards for the last 17 years. They are contracted by the Federal Bureau of Prisons and PA Department of Corrections to provide halfway house services for male and female offenders coming from prison and treatment centers. Offenders are released to us on "Good Conduct Time" and/or for completion of a drug treatment requirement.

This is a four-story, minimum security facility, which may house up to 58 male and female "residents." At the time of their inception they housed only 12 beds and contracted out to the Federal Bureau of Prisons only. It was the BOP that had originally approached Catholic Social Services. They were in the Scranton market looking for an organization to contract out housing services. Having never been in corrections before Scranton CSS put together a bid and won the contract. To this day Scranton CSS is the only confinement facility in Catholic Charities nationwide.

Their mission statement reads, *"Catholic Social Services addresses various needs of all people... assists in strengthening family life and in helping individuals to reach their full potential...promoting a spirit of collaboration and responding with appropriate action on behalf of those who are limited in power, voice and access."*

Their Center philosophy is that our offenders have committed a crime, faced judgment and sentencing, and served their time - it's now time for us to help them return to the community as productive, contributing member of society.

SUMMARY OF AUDIT FINDINGS

At the conclusion of the PREA Audit, the Auditor conducted a post-audit briefing complimenting staff on the work that the Agency's administration and the CSSRRC staff, in particular, has done to comply with the PREA standards at this first PREA Audit. It is evident from the PREA Audit, that policies and protocols have been developed to prevent, detect and respond to allegations of sexual abuse and sexual harassment. I advised the agency that I would complete my interim audit report within thirty (30) days and that the 180 day action plan period would commence at that point in order for any remaining issues to be worked through in order to gain the full measure of compliance required. The CSSRRC staff are commended for successfully meeting 27 PREA standards.

The PREA Coordinator and I worked together to develop a corrective action plan in order to bring the facility into full compliance. There were seven (7) standards which required further action as I determined them to not meet the standard. Over the next thirty-nine (39) days, the PREA Coordinator made the required changes, provided additional documentation and conducted staff training as required to fully comply with all standards.

Number of standards exceeded: 0

Number of standards met: 27

Number of standards not met: 5

Number of standards not applicable: 7

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) Agency Policy 6A-05-1 along with postings in the facilities confirm compliance with this standard.
b) Resident and staff interviews clearly confirmed that the zero tolerance standard is promoted and definitions are well understood.
c) PREA Coordinator confirms ample time and authority to oversee compliance requirements. Based upon organizational structure, size of facility and through staff/resident interviews, the auditor concurs.

Standard 115.212 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

N/A – Agency does not contract with other entities for the confinement of residents.

Standard 115.213 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) Agency Policy 6A-05-1 applies to this standard. Interviews with the CEO and the PREA Coordinator substantiated compliance with their Staffing Plan.
b) The facility has ever deviated from the Staffing Plan. Employees are mandated to remain on duty until relief has arrived.
c) The agency has documentation of reference to PREA consideration when reviewing their Staffing Plan.
d) There are 70 video cameras located at strategic locations throughout the facility. The security cameras are placed to allow maximum

observation by staff. Security staff and the supervisor randomly check camera play back and live footage. All staff at their security stations have access to camera footage at their desktop computer.
e) Given the type and number of residents being served, the configuration of the posts and the floors, the number of staff assigned within the floors, the placement of video monitoring, the privacy within the toilets and showers, and the supervisory leadership of the leadership team , the Auditor concludes that CSSRRC has adequate number and deployment of staff.

Standard 115.215 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) The facility has a policy of never performing strip searches.
b) Each bathroom/shower has a lock to prevent unwarranted viewing.
c) The agency policy requires that no complete undressing occurs in any area except secured bathroom/showers.
d) Agency policy and confirmation through staff/resident interviews concludes that opposite gender staff announce their presence. The Auditor observed staff announcing their presence when entering the floors, the bedrooms, the toilets and showers of the opposite sex.
e) Agency policy prohibits cross gender pat searches. Interviews with staff/residents confirm that even standard pat searches (which policy permits) are rare and none of residents interviewed had ever received one nor could recall whether any other resident did.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6A-05-1 (J), page 18, mandates equal opportunity for residents with disabilities and residents who are limited English proficient to participate in and benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The Auditor reviewed and verified written contracts and invoices with the CDI and AODC who are professional interpreters to assist residents who are limited English proficient or deaf. The Auditor reviewed and verified in the Resident Handbook that the resident is given assistance from the interpreters if needed. The Auditor reviewed and verified that the training curriculum and presentation slides discuss the PREA compliant practices with residents with disabilities. The Auditor confirmed through interviews with staff and residents that resident interpreters are not permitted.

Standard 115.217 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 7B-04 and 7B-05, prohibits the hiring or promoting of anyone and prohibits enlisting the services of any contractor who may have contact with residents who has engaged in sexual abuse in the past, or has been convicted of engaging in or attempting to engage in sexual activity in the community or who has been civilly or administratively adjudicated. Policy 7B-04 further requires a criminal background record check on new employees and contractors who have contact with residents. The Auditor verified that these policies are complied with from the following documentation:
a) interviewed and confirmed with the Executive Director and the PREA Coordinator
b) reviewed and verified in the written application form that the new employee must sign that he/she has not engaged in sexual abuse and have not been convicted of engaging in sexual activity in the community by force or threat of force and have not been civilly or administratively adjudicated and
c) reviewed a sample of personnel files, employee and contractor criminal background checks of individuals hired within the past year.

Standard 115.218 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility, in consideration of improvements to better protect residents and to comply with PREA requirements, greatly improved their video monitoring capacity. Their previous system in 2012 consisted of 30 analog cameras. Their current system includes seventy (70) digital cameras, professionally installed by Triguard Systems. All security staff have access to and are required to randomly view the video monitors in their area, as well as other areas. The Auditor reviewed and observed the video cameras during the facility tour and at subsequent tours of the facility and also observed staff reviewing their cameras on the monitors.

Standard 115.221 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

CSSRRC is not responsible for conducting administrative or criminal sexual abuse investigations as per Policy 6A-05-1Section 4 (A) page 31. The Auditor verified that CSSRRC refers to the BOP and the PADOC for administrative investigation and criminal investigations and a uniform evidence protocol for the Pennsylvania State Police, BOP/PADOC investigators to use when they conduct their criminal investigations.
The CSSRRC offers all victims of sexual abuse access to forensic medical exams at outside hospitals at no cost to the resident. A list of outside hospitals was provided to the Auditor that conducts forensic evaluations by qualified SAFEs and SANEs. Any sexual assault victims at the facility would be transported to Geisenger Community Medical Center in Scranton. The medical center has Sexual Assault Resources available 24/7 as indicated at their web-site (http://www.geisinger.org/for-patients/locations-directions/gcmc/) Within the past 12 months, no forensic medical exams were conducted.
Policy 6A-05-1Section 5 (B)pages 34-36 indicates that emergency medical treatment and crisis intervention services are offered to the victim at no cost to them. A written MOA with the Women's Resource Center (Scranton) is entered into with CSSRRC to provide no-cost victim advocacy and emotional and crisis counseling services 24/7 when needed to the residents at CSSRRC.
The agency will rely on the community Victim Advocates and local Police Departments for assistance with this standard.

Standard 115.222 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) Policy 6A-05-1 Section 4 page 31 covers this standard.
b) The agency would utilize Pennsylvania State Police for criminal investigations.
c) The agency PREA Manual outlines these responsibilities.
d) There have not been any criminal sexual assault investigation in the facility within the past year.

Standard 115.231 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6A-05-1, Section 2 (L), pages 21-22, outlines all 10 areas in the PREA Standard to be included the agency's staff training program. The Auditor verified these topics in the facility's training curriculum, verified that these topics were covered in the presentation slides, asked staff about each of these 10 areas and staff verified that these areas were covered. Relias provides online training during odd years and the PREA Coordinator retrains every other year. In between the training, the facility provides staff with briefings on PREA policies and protocols at mandatory staff meetings. In total, to date, 47 staff members have been trained on PREA although the facility currently only has a staff of 26. The facility maintains exceptional documentation of all trainings provided and requires signed acknowledgements of their receipt and understanding of the training provided at each session

Standard 115.232 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6A-05-1Section 2(M) page 22, mandates specialized training on PREA given by the agency to all volunteers and contractors who have contact with residents. The Auditor verified from the list provided that persons were trained by the agency who were either contractors or volunteers who have contact with residents in the past 12 months. The Auditor reviewed and verified that the training curriculum addresses PREA standards and zero tolerance for contractors and volunteers (same). Policy 6A-05-1 further states that the level and type of training provided shall be based on the services these individuals provide and on the level of contact they have with clients. As with staff and resident training, signatures matching rosters verified compliance.

Standard 115.233 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6A-05-1Section 2(N), pages 22,23specifies that during the intake process, residents shall receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment, their rights to be free from sexual abuse and sexual harassment and from retaliation, and how to report such incidents. A total of 135 residents were given this information at intake in the past 12 months, which represents 100% of the individuals admitted to CSSRRC. The Auditor conducted a spot check of resident's intake records and verified that newly admitted residents were given information by the staff on the agency's policy on zerotolerance. The Auditor interviewed residents who indicated that they were informed of the agency's policy to protect them against sexual abuse and sexual harassment and how to report if they were harmed or felt at risk of being harmed within several hours of admission. The Auditor also verified that the Resident Handbook adequately informs residents of the agency's zero-tolerance policy and of the agency's duty to protect them against sexual abuse and sexual harassment. As with staff and volunteer/contractor training, signatures matching rosters verified compliance. The Auditor verified through interviews with the caseworker who conducts intake functions and with residents that the PREA Notice found in the Resident Handbook is described at intake and the resident signs that they understand their right to be free from sexual abuse and sexual harassment. The auditor confirmed through intake records that residents who have been transferred to CSSRRC from another facility are given refresher training. There were 41 residents who were transferred from a different community confinement facility. To ensure that residents who are limited English proficient or deaf understand this process, PREA posters are displayed in both Spanish and English. The Auditor verified that PREA posters were abundantly displayed throughout the facility. The Auditor reviewed and verified written contracts to confirm that CSS is contracted with an CDI and AOPC certified deaf interpreter. Case managers are also readily available to read the brochure and training to any offender/inmate who is visually impaired or limited in their reading abilities who are professional interpreters to assist residents who are limited English proficient or deaf.

Standard 115.234 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

N/A. The agency does not conduct any investigations, either administratively or criminally.

Standard 115.235 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

N/A The agency does not employ Medical or Mental health staff. Residents in need of medical attention would be transported to Geisenger Community Medical Center, Scranton for treatment.

Standard 115.241 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) Policy 6A-05-1 Section 2(K) is addresses this standard. The caseworkers or the supervisor performs a vulnerability assessment on every resident.
b) Interviews with staff and residents confirmed that the assessment was completed on the day of arrival to the facility.
c) The agency utilizes a comprehensive tool and interview to conduct the screening. The auditor observed the tool and the documentation in random files. . The Auditor verified that each of the variables are rated with a score, and residents are documented in their client record that they are either High, Medium or Low risk for being susceptible towards victimization or abusiveness..

d) Interviews with residents housed over thirty days confirmed follow-up assessments. Every resident meets with a case worker on a weekly basis. PREA considerations are discussed at these weekly meetings.
e) Policy and interviews with intake staff assured compliance with this section of the standard
f) The agency employs a small number of staff. Information is kept in a locked office and staff members are advised concerning potential risk on a need to know basis.
While substantially compliant, the agency should specifically reference in their policy the specific questions that residents cannot be disciplined for refusing to answer.

Standard 115.242 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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CSSRRC uses the information obtained from the risk screening to determine floor and bedroom assignments based on their assessment of susceptibility of risk for abusiveness or victimization. The Auditor verified this practice during the facility tour and through staff and resident interviews. All housing assignments are done by one of only two people.The information is also used by the caseworker to determine programming, community service work and work assignments to minimize the risk of the resident being sexually victimized. Policy 6A-05-1(K9) page 17, states that the admissions department will consider programming arrangements for transgender or intersex clients on a case-by-case basis to ensure the resident's health and safety, and whether the placement would represent management or security concerns. The Auditor verified through the interviews with the residents, including the only one (at the time of the audit) who presented to be lesbian and gay, that they were asked this question at intake. Showering at CSSRRC is very private in single-occupancy bathroom/showers to further protect all individuals from sexual assault. Hallways leading to and from these units are monitored.

Standard 115.251 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6A-05-1 Section 3(B) page 22,23, identifies multiple ways to allow residents to report sexual abuse and sexual harassment and retaliation by other residents or employees Methods of reporting include the following: a. verbal report to a staff member; b. written report to a staff member; c. reporting via mailletter to BCI/PREA Coordinator 1800 Elmerton Ave Harrisburg, PA 17110; d. reporting online via Website at www.tipsubmit.com The Auditor observed the PREA posters displayed within the facility, reviewed and verified the reporting protocol in the Resident Handbook. Policy 6A-05-1 Section 3(B) 6,7,8, states that employees will accept reports verbally, in writing, anonymously, and from third parties. These reports (6A-05-1Q form or DOC-21) will be forwarded to the BOP or DOC, depending upon the resident's originating agency. The Auditor verified from interviews, from the posters, from the forms that this policy is carried out in practice. The Auditor verified through staff interviews the multiple ways staff can report privately sexual abuse and sexual harassment of residents, including verbally reporting it to their immediate supervisor, filing out the form, calling the Sexual Abuse Reporting Phone Line, submitting onlie at www.tipsubmit.com.

Standard 115.252 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

N/A. The agency has no administrative procedure to address resident grievances regarding sexual abuse; therefore CSSRRC is exempt from this standard. Policy 6A-05-1 Section 6(A) states that all resident grievances that involve allegations of sexual abuse or sexual harassment will be forwarded to BOP or DOC.

Standard 115.253 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6A-05-1 Section 5(B), page 35, provides residents access to the Women's Resource Center as the outside victim advocate for confidential emotional support services. The Auditor verified through the Resident Handbook and the Memorandum of Agreement between CSSRRC and the Women's Resource Center that residents will be able to access the Rape Crisis Center at no cost to them for victim advocacy and emotional support services if needed. The auditor also verified that the services are available to both male and femal residents. While the standard is in substantial compliance, the agency must incorporate the method of notification regarding the extent of monitoring into the policy.

Standard 115.254 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6A-05-1 Section 3(B), page 25, states that a report from a family member, friend or any other third party is permitted on behalf of a resident. CSSRRC provides several methods for third parties to report. Friends, family and the general public may report allegations of sexual abuse or sexual harassment at a facility by: 1.. Writing a letter to BCI/PREA Coordinator 1800 Elmerton Ave Harrisburg, PA 17110; 2. accessing the Sexual Abuse Reporting Website at www.tipsubmit.com; 3. contacting the Executive Director/designee (Center Supervisor-PREA Coordinator); 4. contacting the PA Department of Corrections. 5. contacting the Federal Bureau of Prisons. The Auditor verified that a poster is available outlining these methods and it is also reported online. Since these methods go beyond the PREA standard, the Auditor determined that CSSRRC exceeds the minimum. Interviews with staff and residents assured they had knowledge of the option for third-party reporting. There have been zero third-party reports received by the agency within the last 12 months.

Standard 115.261 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6A-05-1 Section 3(C), requires all staff to report immediately any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment. Interviews with staff verified that they understood that they have a duty to report immediately without delay. Reports of sexual abuse would be made to the local police departments and agency supervisors immediately. Same policy prohibits staff from revealing any information related to sexual abuse report to anyone other than to make treatment, investigation and other security and management decisions. At CSSRRC, the procedure is to report this information to the Center Supervisor or Executive Director. The Auditor verified that security staff understood they were to report allegations of sexual abuse and sexual harassment without delay.

Standard 115.262 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

All staff members indicated during interview that their first priority was to protect potential victims. Policy 6A-05-1 (K) page 19 instructs staff members to take immediate action to protect the offender/inmate, including but not limited to transfer, room change, and floor change when applicable. The first staff to respond to the report should separate the alleged victim and the abuser, preserve and protect any crime scene to allow law enforcement to collect evidence and to request the alleged victim and the alleged abuser to not take any actions that would destroy physical evidence.

Standard 115.263 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6A-05-1Section 3(G) addresses this standard. The agency is under contract with the Pennsylvania Department of Corrections and the US Bureau of Prisons and is obligated to notify them if a resident reports abuse in a state/federal prison. Interviews with staff members substantiated their understanding of the need to notify.

Standard 115.264 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6A-05-1 Section 5(A) outline first responder duties. All security staff are considered and trained as first responders. During interviews with staff, I ascertained that they were confident in their knowledge of correct procedures to take when discovering a sexual abuse incident. Policy requires separation of the alleged victim from the alleged abuser, requires staff first responder to lock down the crime scene to preserve and protect physical evidence, requires the victim and the abuser to not destroy any physical evidence by not washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, and requires immediate reporting to the Center Supervisor/Executive Director.

Standard 115.265 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6A-05-1 and form 6A-05-1Q were used to verify that there is a plan in place to coordinate actions to be taken in response to an incident of sexual abuse. The plan provides written guidance to staff and administration regarding actions to take and notifications to be made. A PREA After-Action Checklist (referenced form) for Incidents of Sexual Abuse and Harassment is completed to ensure that all steps of the plan and proper notifications are made. Staff interviewed confirmed that they are knowledgeable of the plan and the necessary actions to be taken in response to an allegation of sexual abuse.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The Catholic Social Services Scranton facility does not have a collective bargaining unit. CSS Scranton confirmed that it would not enter into any collective bargaining agreement that would limit the facility's ability to remove an alleged sexual abuser from contact with residents pending the outcome of an investigation. The Auditor reviewed the employee handbook and verified compliance.

Standard 115.267 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6A-05-1 addresses the policy requirement of this standard. CSS Scranton has as policy to protect residents who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff as outlined in policy 6A-05-1, page 15.

The Center Supervisor/PREA Compliance Manager is responsible for weekly monitoring for retaliation for at least 90 days and longer if there is a continuing need. Monitoring is documented on the Retaliation Monitoring Procedures Log. In the past 12 months, there were zero residents who were monitored for retaliation with, of course zero incidents of retaliation reported. When interviewed, the Center Supervisor/PREA Compliance Manager knew his responsibilities for monitoring for retaliation per policy and requirements of the standard.

Standard 115.271 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

corrective actions taken by the facility.

N/A. The agency has a policy related to criminal and administrative agency investigations however the policy requires that the agency does not conduct them but refers them to the originating agency (BOP/DOC) that the resident was sent from. The agency does not conduct any investigations, either criminally or administratively. The facility policy directs that all staff shall cooperate with outside investigators and the Center Supervisor will remain informed of the progress of the investigation through communication with outside investigators.

Standard 115.272 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

N/A. The agency refers all administrative investigations to the originating agency (BOP/DOC) from where the resident was sent from. The agency does not conduct any investigations, either criminally or administratively.

Standard 115.273 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6A-05-1 Section 4(A,B) addresses this standard and while the agency does not conduct such investigations, it requests the relevant information from the investigating entity in order to inform the resident of the outcome.

Standard 115.276 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

corrective actions taken by the facility.

Policy 6A-05-1 addresses CSSRRC employees regarding discipline and meets all criteria of the standard. There have been no staff members disciplined for agency sexual abuse/harassment policy violations in the last year.

Standard 115.277 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6A-05-1 addresses CSSRRC contractors and volunteers regarding corrective action and meets all criteria of the standard. There have been no volunteers/contractors who have been involved in or alleged to have been engaged in sexual abuse/harassment within the past year.

Standard 115.278 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

N/A. The agency has no role in the disciplinary sanctions for residents. All matters are referred to the originating agency (BOP/DOC) from where the resident was sent from. Federal and state parole officers make determinations and the agency administers any rendered sanctions.

Standard 115.282 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6A-05-1 Section, indicates that residents who are victimized of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, residents who are victims of sexual abuse will be offered medical treatment and offered timely information about and timely access to sexually transmitted infections prophylaxis in accordance with professionally accepted standards of care. The policy requires that these medical and mental health services are provided at no cost to the resident. The agency does not employee medical or mental health practitioners. Residents would be transported to Geisenger Community Medical Center in Scranton, PA.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

MOU is in place and was verified by the auditor for Geisenger Community Medical Center and for the Women's Resouce Center to comply with the requirements of this standard in the provision of medical and mental health care services. Policy 6A-05-1 Section 5 (C) requires a mental health evaluation of all known resident on resident abusers within 60 days.

Standard 115.286 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6A-05-1 page 39 lays out the incident review procedure. The incident review team consists of the Center Director, Center Supervisor/PREA Coordinator, the DOC/BOP investigator, CSS Security staff (as necessary), DOC PREA Coordinator (when necessary).. . The team examines the area where the incident was alleged to have occurred and assesses whether physical barriers in the area may have contributed to the abuse, whether monitoring technology should be deployed or augmented and whether the staffing levels at the time of the incident were adequate.

Standard 115.287 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6A-05 Section 9, states that CSSRRC will track uniform data for every allegation of sexual abuse in its community corrections residential facility and that the data collected answers all of the questions within the latest version of the Survey of Sexual Violence (SSV) conducted by the Department of Justice. The Auditor verified that this form is used by the agency for aggregating the sexual abuse data on an annual basis.

Standard 115.288 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6A-05-1 Section 9, provides that CSSRRC collects and aggregates its data to assess and improve the effectiveness of its community corrections residential programs' prevention, detection, and response policies, practices and training to identify problem areas, to take corrective action and to prepare an annual report of its findings. The PREA Coordinator prepares an annual report that provides the problem areas and corrective actions for each facility and as the agency as a whole. The report includes a comparison of the current year's data and corrective actions with those from prior years and provides an assessment of the agency's progress in addressing sexual abuse. The most recent report was completed in May 2015.
Before making aggregated sexual abuse data public, all personal identifiers are redacted. CCSRRC will publish its annual report at www.cssdioceseofscranton.org. The Auditor reviewed the agency's policy and verified that these policies require that personal identifiers and any specific material that would present a clear and specific threat to the safety and security of the facility be redacted.

Standard 115.289 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6A-05-1 , states that all data will be be securely stored for at least 10 years after the date of its initial collection.

AUDITOR CERTIFICATION
I certify that:

☒ The contents of this report are accurate to the best of my knowledge.

☐ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Daniel M. Engert ____________________ August 24, 2016 ____________

Auditor Signature Date