

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

☐ Interim      ☒ Final

**Date of Interim Audit Report:** Click or tap here to enter text.      ☐ N/A

*If no Interim Audit Report, select N/A*

**Date of Final Audit Report:**      7/5/21

## Auditor Information

<b>Name:</b> Jack Fitzgerald	<b>Email:</b> jffitzgerald@snet.net
<b>Company Name:</b> Fitzgerald Correctional Consulting LLC	
<b>Mailing Address:</b> 87 Sharon Drive	<b>City, State, Zip:</b> Wallingford CT06492
<b>Telephone:</b> 203-694-4241	<b>Date of Facility Visit:</b> May 24-25, 2021

## Agency Information

<b>Name of Agency:</b> Community Resources for Justice			
<b>Governing Authority or Parent Agency</b> (If Applicable): Click or tap here to enter text.			
<b>Physical Address:</b> 355 Boylston Street		<b>City, State, Zip:</b> Boston MA 02116	
<b>Mailing Address:</b> Click or tap here to enter text.		<b>City, State, Zip:</b> Click or tap here to enter text.	
<b>The Agency Is:</b>	<input type="checkbox"/> Military	<input type="checkbox"/> Private for Profit	<input checked="" type="checkbox"/> Private not for Profit
<input type="checkbox"/> Municipal	<input type="checkbox"/> County	<input type="checkbox"/> State	<input type="checkbox"/> Federal
<b>Agency Website with PREA Information:</b> <a href="https://www.crj.org/divisions/social-justice-services/prea/">https://www.crj.org/divisions/social-justice-services/prea/</a>			

## Agency Chief Executive Officer

<b>Name:</b> Deborah O'Brien	
<b>Email:</b> DObrien@crj.org	<b>Telephone:</b> (617) 423-2020

## Agency-Wide PREA Coordinator

<b>Name:</b> Heriberto Crespo	
<b>Email:</b> HCrespo@crj.org	<b>Telephone:</b> (617) 423-2020
<b>PREA Coordinator Reports to:</b> Director of Crime and Justice Institution	<b>Number of Compliance Managers who report to the PREA Coordinator:</b> 8

## Facility Information

**Name of Facility:** LightHouse

**Physical Address:** 115 Glenwood Ave

**City, State, Zip:** Buffalo NY 14209

**Mailing Address (if different from above):**  
Click or tap here to enter text.

**City, State, Zip:** Click or tap here to enter text.

**The Facility Is:**

☐ Military

☐ Private for Profit

☒ Private not for Profit

☐ Municipal

☐ County

☐ State

☐ Federal

**Facility Website with PREA Information:** <https://www.crj.org/divisions/social-justice-services/prea>

**Has the facility been accredited within the past 3 years?** ☐ Yes ☒ No

**If the facility has been accredited within the past 3 years, select the accrediting organization(s) – select all that apply (N/A if the facility has not been accredited within the past 3 years):**

☐ ACA

☐ NCCHC

☐ CALEA

☐ Other (please name or describe: Click or tap here to enter text.

☒ N/A

**If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe:**  
The facility undergoes internal audits of community correctional practices as well as site visits completed by the US Bureau of Prisons.

### Facility Director

**Name:** Kimberly Kadziolka

**Email:** KKadziolka@crj.org

**Telephone:** 716-783-8383

### Facility PREA Compliance Manager

**Name:** Kimberly Kadziolka

**Email:**

**Telephone:** 716-783-8383

### Facility Health Service Administrator ☒ N/A

**Name:** 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:**

38

**Current Population of Facility:**

26

Average daily population for the past 12 months:	23	
Has the facility been over capacity at any point in the past 12 months?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Which population(s) does the facility hold?	<input type="checkbox"/> Females <input type="checkbox"/> Males <input checked="" type="checkbox"/> Both Females and Males	
Age range of population:	24-64	
Average length of stay or time under supervision	4 months	
Facility security levels/resident custody levels	Community/ Reentry	
Number of residents admitted to facility during the past 12 months	106	
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:	103	
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 30 days or more:	88	
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
<p>Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):</p>	<input checked="" type="checkbox"/> Federal Bureau of Prisons <input type="checkbox"/> U.S. Marshals Service <input type="checkbox"/> U.S. Immigration and Customs Enforcement <input type="checkbox"/> Bureau of Indian Affairs <input type="checkbox"/> U.S. Military branch <input type="checkbox"/> State or Territorial correctional agency <input type="checkbox"/> County correctional or detention agency <input type="checkbox"/> Judicial district correctional or detention facility <input type="checkbox"/> City or municipal correctional or detention facility (e.g. police lockup or city jail) <input type="checkbox"/> Private corrections or detention provider <input type="checkbox"/> Other - please name or describe: <a href="#">Click or tap here to enter text.</a> <input type="checkbox"/> N/A	
Number of staff currently employed by the facility who may have contact with residents:	21	
Number of staff hired by the facility during the past 12 months who may have contact with residents:	5	
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	0	
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	0	
Number of volunteers who have contact with residents, currently authorized to enter the facility:	0	

## Physical Plant

<b>Number of buildings:</b>  Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.	2
<b>Number of resident housing units:</b>  Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.	3
<b>Number of single resident cells, rooms, or other enclosures:</b>	0
<b>Number of multiple occupancy cells, rooms, or other enclosures:</b>	18
<b>Number of open bay/dorm housing units:</b>	0
<b>Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?</b>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No    43 cameras
<b>Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?</b>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>Medical and Mental Health Services and Forensic Medical Exams</b>	
<b>Are medical services provided on-site?</b>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>Are mental health services provided on-site?</b>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

<p><b>Where are sexual assault forensic medical exams provided? Select all that apply.</b></p>	<p><input type="checkbox"/> On-site</p> <p><input checked="" type="checkbox"/> Local hospital/clinic Erie County Medical Center Hospital</p> <p><input type="checkbox"/> Rape Crisis Center</p> <p><input type="checkbox"/> Other (please name or describe: <a href="#">Click or tap here to enter text.</a>)</p>
<p align="center"><b>Investigations</b></p>	
<p align="center"><b>Criminal Investigations</b></p>	
<p><b>Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:</b></p>	<p align="center">0</p>
<p><b>When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.</b></p>	<p><input type="checkbox"/> Facility investigators</p> <p><input type="checkbox"/> Agency investigators</p> <p><input checked="" type="checkbox"/> An external investigative entity</p>
<p><b>Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)</b></p>	<p><input checked="" type="checkbox"/> Local police department</p> <p><input type="checkbox"/> Local sheriff's department</p> <p><input type="checkbox"/> State police</p> <p><input type="checkbox"/> A U.S. Department of Justice component</p> <p><input type="checkbox"/> Other (please name or describe: <a href="#">Click or tap here to enter text.</a>)</p> <p><input type="checkbox"/> N/A</p>
<p align="center"><b>Administrative Investigations</b></p>	
<p><b>Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?</b></p>	<p align="center">4</p>
<p><b>When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: Select all that apply</b></p>	<p><input checked="" type="checkbox"/> Facility investigators</p> <p><input checked="" type="checkbox"/> Agency investigators</p> <p><input checked="" type="checkbox"/> An external investigative entity</p>
<p><b>Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)</b></p>	<p><input type="checkbox"/> Local police department</p> <p><input type="checkbox"/> Local sheriff's department</p> <p><input type="checkbox"/> State police</p> <p><input checked="" type="checkbox"/> A U.S. Department of Justice component (FBOP – Regional Staff)</p> <p><input type="checkbox"/> Other (please name or describe: )</p> <p><input type="checkbox"/> N/A</p>

## Audit Findings

### Audit Narrative (including Audit Methodology)

*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 completed 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.*

The Prison Rape Elimination Act (PREA) audit of the Community Resources for Justice (CRJ) LightHouse facility in Buffalo, NY, took place on May 24-25, 2021. The audit was conducted by Mr. Jack Fitzgerald, United States Department of Justice Certified PREA Auditor. LightHouse is one of CRJ's eight adult residential reentry programs that support men and women leaving correctional environments. By providing structure and supportive living and access to education, treatment, and employment, they hope to provide a smooth transition from an institutional setting to living in the community. CRJ has broadened its mission through the years, but its experience with serving criminal Justice clients can be traced back to 1878. Today, the Social Justice Services division, which encompasses LightHouse, is one of a three-part organization that makes up CRJ. The agency's Community Strategies Division looks to support adults with developmental and intellectual disabilities. The third portion of the agency, the Crime and Justice Institute, is committed to improving public safety and justice delivery throughout the country. The Crime and Justice Institute completes research, provides technical assistance, and supports policy and legislative change on many issues in both the adult and juvenile justice arenas.

The Auditor and Community Resources for Justice began discussions on LightHouse's PREA Audit's potential dates in December of 2020. A contract for Auditing Services was finalized on March 31, 2021. The Auditor provided an audit notice in two languages to the facility. The Facility Administrator posted the notice in English and Spanish, the two most common languages spoken at LightHouse. The Auditor was provided with a picture of the postings up six weeks in advance of the Auditor's planned site visit. The notice provides residents with information about the audit, how to contact the Auditor, and the mail's confidential nature. The notice did not result in any confidential communication from staff, residents, or other interested parties.

The contract language includes an attachment that outlines the Audit process over three phases (Pre-Audit, On-Site, and Post Audit), including corrective actions if needed. The Auditor received a flash drive containing files supporting the Pre-Audit Tool information in April. During the Pre-Audit phase, the Auditor worked with CRJ's PREA Coordinator, Heriberto Crespo, the Assistant Director of Standards and Quality Assurance. Information was exchanged through emails and phone contact to provide clarity of information provided and where additional information to support compliance was requested. The Auditor provided during the Pre-Audit phase a review of information submitted with questions on information provided or request for additional information to support compliance. Information was provided to the Auditor in advance of the site visit with other documents provided during the site visit. The Auditor provided the agency with a tentative idea of the audit day during a call, including approximate times on-site and the list of targeted populations that would need to be identified. The Auditor encouraged the agency to use the information online about the audit process to work with staff, so they had an increased level of comfort to what the audit process was and what to expect. The Auditor arrived in Buffalo on May 23, 2021. The Auditor arrived at the facility at 7:45 am on May 24th. Program Monitors, whose position is the primary staff responsible for custody supervision in LightHouse, greeted the Auditor. The Auditor provided identification and received a copy of the facility PREA brochure consistent with the files' documentation. After some informal interactions with staff, the Auditor was escorted to the staff break area that would serve as the interview space. The Auditor, staff, and residents all wore masks throughout the two days.

A virtual entrance meeting was held with Mr. Crespo, LightHouse Director Kimberly Kadziolka, Assistant Director Jackie Diggs, CRJ's VP of Human Resources and Culture Director Pierre Lubin, HR Manager Monique Mosho, Julie Finn SJS Implementation Manager and Talent Acquisition Specialist Stacey Newman. The Auditor thanked the facility for their work to prepare the Pre-Audit tool and supporting

documentation. The Auditor then explained his background and experience in auditing, the audit's goals, and what to expect throughout the two full-day visit. The Auditor reviewed the tentative schedule of tours, interviews, supporting documentation verifications, and expected to be on-site for 18 to 20 hours over the two days. The Auditor was on-site for a total of 18.75 hours in the two days (Day 1 7:45a-6:00p, Day 2 6:30a-2:30p), allowing for observation of staff and resident interactions across the three shifts. The Auditor finished the meeting by reviewing the fairness of the process, the reason for the interviewees' random selection, and how the Auditor formulates conclusions in determining compliance. The Auditor received the current population roster for the facility, which included 23 residents. In October, the Auditor had completed the interviews for the Agency Head, PREA Coordinator, and Human Services Director in Boston, MA, at a facility near their corporate offices.

Administrative Interviews	
Agency Head	Ellen Donnarumma Vice President of Justice Services
PREA Coordinator	Heriberto Crespo- Assistant Director of Standards and Quality Assurance
Hiring	Former Human Resource Director Ted Waterman
Facility Director/ Investigator	Kimberly Kadziolka, Director of LightHouse

The Auditor utilized regional resources identified by the facility to address specialized interview topics that the agency does not employ. These resources available in the community included a local rape crisis agency, a local hospital with SAFE/SANE trained staff, mental health clinics, and medical clinics. This process aimed to ensure enough resources were available to the clients in a sexual assault. The Auditor received information by email or through direct communication with individuals outside LightHouse to assist in determining standard compliance. The Auditor also did web-based searches for news stories, state laws related to mandated reporting, and state-required protocols for sexual assault case handling and SAFE/SANE Certification process requirements. Finally the Auditor spoke with representatives of the Federal Bureau of Prisons Regional Office in Pittsburg, which oversees the LightHouse contract. This call was to determine if there were any concerns from the FBOP directly or the prior clients might have reported about the program.

The LightHouse does not employ individuals who provide Medical, Mental Health, SAFE or SANE services. As an FBOP site, the residents have access to FBOP approved mental health services. CRJ has added an agency-wide clinical mental health professional who aids case management staff in making service referrals and providing crisis support services. Resident victims of sexual assault can receive follow up services through the Erie County Medical Center's clinic. The New York Department of Health has designated three hospitals in Buffalo to be SAFE designated hospitals in the county, including the aforementioned Erie County Medical Center.

LightHouse has not had a staff who has acted in First Responder's role since opening their doors in 2020. The facility does not subcontract for the housing of residents and prohibits all cross-gender searches of residents. Where appropriate, the Auditor utilized information from random staff interviews to determine compliance in his review of standards. Community Resources for Justice employs several individuals who have completed the National Institute for Corrections' training on Investigating Sexual Abuse in a Correctional Setting Including the Facility Director of each of its facilities. The Director was interviewed as the facility Investigator. She was aware of the importance of communication lines during an actual sexual assault investigation at LightHouse. She reported she would involve several agencies, including the Buffalo Police, Erie County Medical Center, Crisis Services, CRJ administration, and the FBOP regional representative. There is an Intake Release Coordinator at LightHouse who perform the intake and the PREA screenings on all new admissions. There were three intakes during the visit, but due to COVID -19 protocols, the Auditor could not observe the intake. The Auditor asked to be taken through the steps to complete the PREA screening and intake by the Intake Release Coordinator.

Specialized Staff Interviews
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Positions described in standards	Title or agency that provided information to answer required questions.
Agency Contract Administrator	N/A – no subcontracted beds
Medical Staff	Erie County Medical Center
Mental Health Staff	Community Based Services funded by Federal Bureau of Prisons
Individuals who have done cross gender searches	N/A Agency Policy prohibits all cross-gender searches.
Administrative Staff	Director of Human Resources
SAFE/SANE	Erie County Medical Center
Volunteers or Contractors who have contact with residents	N/A
Investigative Staff	Assistant Director of LightHouse
Screening Staff	Intake and Release Coordinator Case Management Staff
Intake Staff	Intake and Release Coordinator
Local Rape Crisis Agency	Crisis Services
Individuals responsible for retaliation monitoring	Facility Director
First Responder	Random staff answers were used since no individual has had to act as a first responder.

The Auditor worked with the facility Administration to identify *Targeted Residents* for interviews to be completed. The current population makeup did not allow for the identification of residents in each of the targeted categories for Community Confinement facilities as promulgated by Auditor Handbook. LightHouse did not have any current residents who identified as Transgender or Intersex, nor did they have any individual who had made a claim of sexual abuse in the facility. Due to the small population (25 residents) the program only was able to identify 5 individuals for targeted resident questions. These individuals included individuals with a physical-disabilities, Cognitive challenges, individuals with sexual abuse histories identified during screening, and individuals who identified as LGBTI or gender non-conforming. The Auditor also ensured the oldest and youngest individuals in the population were interviewed since limited targeted populations were identified.

Resident Interviews for facilities with 0-50 population		
	# Interviews Required	# of Interviews Completed
Random Residents	5	7
Target resident Interviews	5	5
Resident with Physical Disability	1	3
Resident who are blind, Deaf, or hard of hearing		
Residents who are LEP		
Residents with a Cognitive Disability		
Resident who Identify as Lesbian, gay, or Bisexual	1	1
Residents who Identify as Transgender or Intersex	1	0



Resident who reported Sexual Abuse	1	0
Resident who reported victimization during screening	1	1
Total	10	12

The LightHouse did not have any allegations of sexual assault or sexual harassment since opening its doors in 2020. The Auditor reviewed the Agencies third-party reporting system and its annual report on PREA to determine if LightHouse data was included. This information was documented in reports provided to the Auditor and publicly available on the agency website. The Auditor confirmed this information with the agency and facility staff, and residents while on site. The Auditor also confirmed with community agencies and referral sources that they were not aware of any such complaints. As a result, there were no criminal or administrative investigative files to review. Similarly, there were no PREA related Grievances; this was confirmed through discussions with the facility Director and the residents.

The Auditor was provided hard copy documentation and shown the electronic case management system *Secure Manage* while on site. A total of 10 current and former client files were reviewed in the pre-audit and on-site phases. Additional internal agency reports were shown to the Auditor while on-site to support ongoing mechanisms in place to ensure initial screening and 30-day reassessments of PREA risks are being monitored for timeliness. The Auditor requested dates for various staff records elements that support compliance in advance of the site visit. The agency provided information on all 17 employees who were employed six weeks before the site visit. The Auditor was provided the requested Human resource record for inspection. The Auditor completed a phone interview with the Human Resource Director, confirming the information proved on the employee files and the agency's process around hiring and discipline of staff.

Onsite Documentation Reviews			
Client Files	Total population	23	10 files
Human resource files	Total Staff	16	6 reviewed
Medical record	No Medical services on site		
Mental health records	No Mental Health services on site		
PREA Grievances	No Grievances filed		
Written request or third-Party Complaints	No filings related to PREA		
Number of PREA Sexual Abuse Investigations	There were no claims of Sexual Assault or Sexual Harassment		

At the closure of the second day, the Auditor held an exit meeting. In attendance was the Director of Reentry Operations, the CRJ PREA Coordinator, the Facility Director, Intake and Release Coordinator, and the Case Managers. The Auditor thanked the members of the team for a supportive audit process by which staff and residents were easily accessible. The Auditor reviewed some of the staff and resident comments during the audit process, which supported a positive environment. Residents reported the facility is safe especially related to PREA and could approach staff with a problem and felt it would be looked into. The Auditor discussed things that could aid in documenting files moving forward. Finally, the Auditor described the post-audit process, which will require the Auditor to review the sum of all information provided, including documents, interviews, and observations. The Auditor went on to state the process must include how all indicators of the PREA standards must be considered in determining compliance.

During the post-audit phase, the Auditor continued to pursue information from community resources. Assess documentation for consistency of practice and overall standard compliance. The PREA Coordinator and the auditor spoke to confirm clarifications of information when needed.

## 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 LightHouse consists of a three-story brick structure at 117 Glenwood Ave in Buffalo NY. The Community Confinement facility is in an urban residential area approximately 2 miles to the downtown areas. The facility is set further off the road than the neighboring properties behind a former residential home also owned by CRJ. The Facility was previously used as reentry facility and was bought and renovated when CRJ was awarded the contract. The facility serves both male and female residents being released from federal correctional environments or individuals who have violated Federal Probation conditions. The facility does not house immigration (ICE) detainees or individuals for the US Marshals Service. The facility provided data supporting its population over the last 12 months; the average population was 23, with approximately 106 admissions, including those on home confinement. As a community release facility, the majority of residents go into the community daily for employment and treatment services. Former clients are monitored on home confinement by the program's staff for several months post-release. The entrance points and are monitored by staff and recorded. Residents are pat searched, or wand searched upon return from the community, and residents are subjected to urine screens monitored by the same gender staff as the resident.

After completing COVID-19 Monitoring protocols on day one of the audit, the LightHouse Assistant Director provided the Auditor with a tour of all spaces in the facility, including locked, secure spaces normally off-limits to residents. The Tour began with a walk-through of the residential space. The primary housing floors for males are on levels two and three. Female bed space is on the first floor as is ADA space that can be used for males or females these rooms also have private bathroom space. The room sizes are two person except in the four beds female room. The bathrooms on the upper floors are multi-person spaces with multiple showers and toileting facilities. There is also a half bath on the first floor where urine tests are done with the residents.

The 38 bed capacity is lower than their zoned capacity of 42 which was done purposefully to increase staff presence in the building. CRJ in redesigning the space deployed office space across the various levels allowing for additional monitoring by case management staff, the employment specialist, and the intake coordinator. There are nine (9) bedrooms on both the second and third floors with two offices. There is also office space on the landings between the floors allowing for additional observation of resident movement in the facility. The first floor includes the main entrance to the building, a program monitoring station and the kitchen and dining space. The program monitoring station provides direct sight to the entry point to the program. The program monitoring station has large screen whereby the 43 internal and external cameras can be observed. The system allows for all cameras to be monitored at once, a particular camera or groups of cameras to be observed by the Program Monitors. The video system also allows for staff to zoom in on a target area for clearer observation of resident activities. The Program Monitor space is always staffed and has computers for the staff to record resident movement on the agency electronic case management system Secure Manage. The front door is secured and on camera, and visitors must be let in. PREA related materials were provided upon arrival to the facility, as was the notice of the audit. The first floor also serves as a check-in point for all residents when entering or exiting the facility and where formal counts are done. The client common area is adjacent to the monitoring station, which allows staff to interact with the residents. Food services are delivered daily by a local vendor who is always escorted by staff onsite to ensure any limited interactions. The food delivery individuals are also educated about PREA and the resident's safety. The facility has a basement mechanical room that is locked, a laundry room, male TV room and a staff breakroom that is also locked. Staff performs random tours of the facility, including bedrooms and bathrooms, hourly. Residents confirm all staff of opposite gender knock and announce presence

when entering any bedroom or bathroom. Program Monitors staff are aware of blind spots in the facility and will add additional tours to areas if residents congregate in these areas. Each of the bedrooms provides resident with a bed and an areas for personal storage. The agency has a dress code for residents when in common areas. In bedrooms, all residents must be fully clothed while sleeping to eliminate incidental viewing incidents.

In front of the residential facility is a house with a garage that is owned by CRJ. The previous vender used this as administrative space but CRJ is only authorizing it as a meeting or training space for staff. Residents are prohibited from entering the space and only the Director and Assistant Director have keys to the building. CRJ's Director of Reentry Services discussed the decision process of not using the house for client services and keeping more staff in the residential building would improve supervision, ensure daily contact between administration and residents, all of which improve the safe feeling for residents. Interviews with the LightHouse Director and Assistant Director both echoed the value of being able to hear and observe staff and resident contacts from their offices on the housing floors. The facility has some raised gardens for fresh vegetables in the rear of the facility and the front area has a lawn and a picnic table for resident to be able to go sit outside. Males and female resident are kept apart or under direct supervision when they are in the same area internally or externally. As a reentry facility the residents go into the community for work and approved treatment. The facility has a dedicated staff person who works on aiding employment search as well as completing site visits to the resident at work. Case managers provide direct emotional support, during the resident's transition and will aid them in planning during their stay including helping them obtain services, identification and when needed treatment.

The LightHouse Director, throughout the tour, showed her knowledge of the standards and potential blind spot hazards and discussed practices employed to address the safety of clients. She described how PREA screening information effect room assignments and how the second-floor rooms have been used as quarantine space for new residents coming into the house during the pandemic.



## Summary of Audit Findings

*The summary should include the number and list of standards exceeded, number of standards met, and number and list of standards not met.*

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

### Standards Exceeded

**Number of Standards Exceeded:** 2  
**List of Standards Exceeded:** 115.211, 115.215

### Standards Met

**Number of Standards Met:** 40

### Standards Not Met

**Number of Standards Not Met:** 0  
**List of Standards Not Met:**

## 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.*

#### Policies and written/electronic documentation reviewed.

LightHouse Pre-Audit Questionnaire  
Policy 900 Staff and Resident Sexual Misconduct  
PREA Coordinator Training  
2019 Memo naming PREA Coordinator

FBOP Statement of Work  
CRJ Organizational Chart  
SJS/SQA meeting notes  
SQA Audit reviews for LightHouse

**Individuals interviewed/ observations made.**

Vice President for Justice Services  
Director of Reentry Services  
PREA Coordinator

**Indicator Summary determination.**

**Indicator (a).** Community Resources for Justice has a policy that mandates zero tolerance toward sexual assault or sexual harassment at all its facilities. Policy 900.00 Staff and Resident Sexual Misconduct includes the statement, "CRJ has a zero-tolerance stance towards all forms of sexual abuse and sexual harassment and is applicable to residents, staff, volunteers, visitors, and contractors. The zero-tolerance stance includes education, prevention, detection, and responding to sexual abuse and sexual harassment incidents immediately." The policy outlines the LightHouse and the agency's efforts to prevent, detect, and respond to sexual abuse or sexual harassment incidents. The 22-page policy covers different aspects of protecting, detecting, and responding to sexual abuse or sexual harassment incident. Interviews with random residents support a zero-tolerance environment exist at LightHouse. Residents support that staff address negative behaviors. They report that if they were to voice a concern, they believed it would be taken seriously and stated the environment is safe from sexual misconduct. Random staff were able to identify key information on training, act as a first responder, and give examples of things they do in their job that supports a PREA safe environment. The LightHouse program is a new Reentry Facility for CRJ and discussions with the Director of Reentry Services supported the safety planning which included thoughts on PREA that went into the redesign of the complex.

**Indicator (b).** Community Resources for Justice has an individual assigned to oversee the agency's efforts toward compliance with the Prison Rape Elimination Act (PREA). Heriberto Crespo is the agency's PREA Coordinator. Mr. Crespo is the agency's Assistant Director of Standards and Quality Assurance (SQA). The PREA Coordinator works with the heads of the CRJ's eight adult community confinement facilities and the Social Justice Services Division's senior leadership to track incidents, provide support to identified needs, and ensure all investigations are completed consistent with agency expectations and standard requirements. Both the PREA Coordinator and Vice President for Justice Services confirm the PREA Coordinator's ability to develop and implement policies and procedures to further ensure residents' sexually safe confinement across the agency. As the Assistant Director of Quality Assurance, Mr. Crespo has routine dealings with the residential directors, including the LightHouse Director. The Agency provided the Auditor with the agency management flowchart and a letter confirming his agency-wide role as PREA Coordinator. Further supporting the PREA Coordinator's access to the executive and division leadership was a meeting minutes for SQA and Social Justice Leadership. The Auditor was also able to review SQA audits of the facility which does a review of documentation to ensure consistence and compliance with standard expectations.

**Compliance Determination**

The information in Policy 900.00 Staff and Resident Sexual Misconduct supports zero-tolerance expectation towards any form of sexual assault or sexual harassment. Policy 900.00 goes on to address the role and responsibilities of the PREA Coordinator (page 3). Interviews with Vice President



for Justice Services and the PREA Coordinator confirm there are sufficient resources in place toward prevention, detection, and responding to any allegation of sexual abuse or sexual harassment. The Policy addresses numerous aspects of the agency's efforts to provide a zero-tolerance environment. The other supporting documentation provided confirms the PREA Coordinator's role in ensuring compliance with the standards. LightHouse residents confirmed the safety of the program and would feel safe to address concerns with staff. The Auditor also considered the staff members' knowledge of PREA training and zero-tolerance expectations in determining compliance. The Auditor supports the standard is exceeded. The agency requires each program to have the Director or Assistant Director to serve as a PREA Manager. This process supports that the requirements of PREA are understood at the facility level and that PREA is part of the facility's culture. The documents and interviews support a close relationship between the facility management and the CRJ PREA Coordinator. Documents show PREA data is regularly reviewed at all levels of the agency. Documents reviewed and interviews support the PREA Coordinator's access to agency leadership to promote change or allocation of resources when needed. The Auditor also took into consideration the steps taken to redesign the facility including moving the caseworkers and administration into the main building to improve observation of residents and access for the residents to facility leadership. It should also be noted that the previous facility at this site was reportedly not able to come into PREA compliance.

## **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.) ☐ 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.*

#### Policies and written/electronic documentation reviewed.

LightHouse Pre-Audit Questionnaire  
CRJ Agency Website

#### Individuals interviewed/ observations made.

PREA Coordinator

#### Indicator Summary determination.

**Indicator (a).** LightHouse is not a public agency; it is a contracted facility funded by the US Federal Bureau of Prisons. It does not subcontract beds to any other vendor.

**Indicator (b).** LightHouse is not a public agency; it is a contracted facility funded by the US Federal Bureau of Prisons. It does not subcontract beds to any other vendor.

**Indicator (c).** LightHouse is not a public agency; it is a contracted facility funded by the US Federal Bureau of Prisons. It does not subcontract beds to any other vendor.

#### Compliance Determination

The standard is compliant. Currently, there is no subcontract of beds with any other agency. LightHouse is part of the Community Resources for Justice a private non-profit organization. Information was confirmed through discussions with the Agency PREA Coordinator and the Auditor's review of the agency website.

## 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 facility have a documented staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?
- ☒ Yes ☐ No In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The physical layout of each facility?  
☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The composition of the resident population? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The prevalence of substantiated and unsubstantiated incidents of sexual abuse? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors? ☒ 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

*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.*

#### **Policies and written/electronic documentation reviewed.**

LightHouse Pre-Audit Questionnaire  
Policy 900.00 Staff and Resident Sexual Misconduct  
FBOB Statement of Work- Staffing requirements  
LightHouse Staffing Plan 2020  
Light House Staffing Plan 2021  
LightHouse floorplans w/ camera location and blind spots  
CRJ Annual PREA Report  
CRJ Board Meeting Minutes/ budget approval  
PREA Coordinator Memo on the review process

#### **Individuals interviewed/ observations made.**

PREA Coordinator  
LightHouse Director  
Random Residents  
Random Staff  
Staffing consistent with schedule

#### **Indicator Summary determination.**

**Indicator (a).** LightHouse has developed a narrative staffing plan that describes the number of staff per shift to provide adequate supervision of the residents in promoting a safe environment. The narrative document addresses the facility's physical layout and the location of cameras that support active supervision. The 13-page documentation addresses the various elements required in indicators (a) and (c). As a Federal Bureau of Prison-funded facility staffing expectations are part of the contractual document which was provided. In speaking with the agency leadership, it is clear they take into consideration all incidents, not just PREA events, in deciding staffing and video surveillance needs. The Agency's staffing plan covers staffing assignments, the physical plant's layout, the placement of cameras, and identified blind spots. The document also covers the current makeup of the population and the frequency of PREA related incidents.

During the onsite portion of the audit, the Auditor was able to see the cameras' locations and the positioning of offices that support residents' supervision. The facility has had no allegations of sexual assault since opening the facility, and when redesigning the facility, they added cameras to improve supervision. Policy 900.00 (page 4) addresses this indicator's elements by defining the staffing plan's

content expectations. Interviews with the facility Director and the Vice President of Social Justice Services further support knowledge of the elements to be considered initially and in an annual review. The Auditor also reviewed the staffing schedule, including the non-custodial positions, to compare against client schedules. This supports that additional resources are available to monitor interactions when there is larger movement in the facility.

**Indicator (b).** LightHouse has not had a situation where they have not met the facility's minimum staffing since opening the facility just over a year prior. This was confirmed with the Program Director and Assistant Director, who reports they have the capacity to mandate coverage or request volunteers in an emergency to provide support. The Director reports they try to avoid requiring staff to stay and will adjust administrative staff schedules to ensure minimums are met at all times. The facility has had turnover in the first year but actively are recruiting staff. The Auditor was able to meet two of three new individuals who were just beginning their training as Policy 900.00 Page 4 states, "If a deviation ever occurs in the staffing plan, it is documented, and the reason for noncompliance is justified." The program has a minimum complement of 2 staff. The program prefers having staff of both genders on at all times. The Program has also trained per diem employees to also fill shifts. The staffing plan document shows that additional program monitors are available on the second shift when the greatest number of residents are awake and in the residence. The schedule also show that case management staff and administrative staff who are not normally part of the minimum have regular work hours that include night and weekend hours. The Facility Director reported if the program was at risk of being below minimum, the Director, Assistant Director, or other have staff come to provide relief if necessary. The program can mandate staff to stay to cover all outs.

**Indicator (c).** LightHouse has a process in place by which the Director reviews the existing plan for adequacy in providing a safe environment for residents. In an interview with the Auditor, the Program Director states that they consider any findings from a PREA event or any other situation where the safety or security of the building was compromised. The PREA Coordinator also confirmed that administration would be consulted on any long-term changes and additions of resources such as video surveillance equipment. Documentation was provided supporting a review meeting was completed in April that included the PREA Coordinator. Vice President for Justice Services and Program Director confirm that immediate solutions would be put in place to resolve identified risk from incident reviews or investigations. The Vice President supports Community Resources for Justice's commitment to providing a safe environment at all times for the residents of LightHouse.

### **Compliance Determination**

LightHouse is compliant with the expectations of standards 115.213. The facility had a written plan that discusses the elements described in indicator (a) and a process for the annual review of staffing and technological needs to support residents' safe management. The staffing plan development reportedly was guided by the contractual guidelines of the Federal Bureau of Prisons and standards promulgated by the American Correctional Association. The Auditor reviewed the FBOP statement of work document which sets guideline for agencies and found the current staffing plan to be consistent with those measures. FBOP guideline ensure the staff monitoring the residents are dedicated to this purpose. The Community Resources for Justice supports the facility by providing additional resources when necessary evidence of this can be found in the hours in which they have added additional staff to the schedule and that case worker positions work nights and weekends. Interviews support regular discussion between facility and agency management and an expectation to resolve identified concerns immediately. Further confirming the agency's expectation is policy 900.00 Staff and Resident Sexual Misconduct that put forth requirements consistent with the standard's language. Residents supported the environment is safe and staff are available. Compliance is based on documentation provided, policy, FBOB guidelines, interviews and the auditors observation during the two-day visit.

## 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 the facility does not have female 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 the facility does not have female 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? (N/A if the facility does not have female residents). ☒ Yes ☐ No ☐ NA

### 115.215 (d)

- Does the facility have policies 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 have procedures that enables 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

*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.*

#### Policies and written/electronic documentation reviewed.

LightHouse Pre-Audit Questionnaire  
 Policy 900.00 Staff and Resident Sexual Abuse  
 Policy 1.4.5 Searches  
 Policy 2.4.5 Urine Collection  
 Training Materials on searches and working with LGBTI residents.  
 Training attendance records.

#### Individuals interviewed/ observations made.

Program Director  
 Random Staff  
 Random Residents



## Indicator Summary determination.

**Indicator (a).** LightHouse has a policy prohibiting cross-gender strip or body cavity searches of a resident except in an exigent circumstance. Policy 900.00 Staff and Resident Sexual Misconduct states, "CRJ authorizes only one type of body search, a pat frisk." The Auditor was also provided with a copy of the facility search policy (1.4.5 Searches), which had consistent language prohibiting such searches. Interviews with administration, random staff and residents confirm no instances in which a strip or body cavity search occurs. Because the facility requires urine samples to be observed, the Auditor checked the policy and practice as part of determining compliance. The facility requires the same gender staff to observe the collections of urine samples for drug testing. Policy 2.45 Urine Collection (page 2) requires "Only a staff member of the same sex shall collect urine specimens for analysis from a resident." The Auditor asked random staff related questions about how this process occurs, including if cross-gender observations would ever occur. Residents interviewed confirmed that the same gender staff always collects urine samples. The agency has also used oral tests with transgender individuals in the past.

**Indicator (b).** LightHouse serves both male and a small number of female residents. The agency does not allow for cross-gender pat searches of LightHouse residents, even in exigent circumstances. Policy 900.00 states, "Pat frisk searches will be conducted by gender, male staff to male resident and female staff to a female resident." Interviews with residents confirm that cross-gender pat searches have not occurred. Female residents also confirmed that they have not been prohibited from attending programming or outside opportunities due to a lack of female staff to complete searches. Agency practice is if a male staff were working at the LightHouse facility, wand searches would occur if the female staff were occupied with other duties. The facility currently has more female staff than male staff. The residents further confirmed that they are never prohibited from attending programming or employment due to the lack of female staff. LightHouse currently has more female employees than male staff. Pat searches, like urine testing are required to be same gender staff as the resident. Interviews with random staff at LightHouse also confirmed cross-gender pat searches of female residents would not be permitted. LightHouse Director confirmed that in the past 12-months, female residents were not prevented from attending outside programming due to the lack of female staff. The Auditor's interview with random residents confirmed the same gender practices of the LightHouse. As such, there were no documents for the Auditor to review of exigent circumstances.

**Indicator (d).** Community Resources for Justice, Policy 900.00 Staff and Resident Sexual Misconduct has language that addresses this indicator's requirements. The policy protects residents from being viewed in any state of undress except in incidental view on security rounds. The Policy states, "Residents at the program are able to shower, perform bodily functions, and change clothing without a staff of the opposite gender viewing their buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine room checks." "Staff of the opposite gender announces their presence when entering a resident room or bathroom where residents are likely to be showering, performing bodily functions, or changing clothes. (page 9)." The Auditor observed opposite gender staff making announcements before entering bedrooms or bathrooms at LightHouse. The Auditor also confirmed with residents that they can shower, use the bathroom facilities, and get changed without the opposite gender staff seeing them. LightHouse residents also supported that staff knock and announce before entering resident rooms or bathrooms.

**Indicator (e).** The LightHouse Director and random staff interviewed confirm they would not search an individual to determine genital status. Policy 900.00 (page 9) states, "Staff are prohibited from searching or physically examining a transgender or intersex resident for the sole purpose of

determining the resident's genital status." As noted in indicator a) the facility does not perform any strip searches of clients. The Intake and Release Coordinator reports that if a person's genital status were unknown, they would ask them. LightHouse is a community confinement facility; all admissions are scheduled, and residents' information would likely be obtained in advance. There were no current Transgender individuals in the population.

**Indicator (f).** The Community Resources for Justice ensures all staff at LightHouse have been trained in performing cross-gender searches or searches of transgender individuals. Staff report they have been trained to search residents with the back of their hands, be aware of the past trauma the resident might have had, and respectfully communicate with the resident. Random staff confirmed that they had received the training on searches and were able to describe what they learned. Training records and training materials provided confirm they have received appropriate training. The Agency uses the resources created by the Moss Group on cross gender and transgender searches.

#### **Compliance Determination.**

The agency has policies in place that addresses the standard requirements consistently (Policies, 1.4.5, 2.4.5, 900.00). Community Resources for Justice have implemented a policy of no strip searches or body cavity searches and no cross-gender pat searches (Policies 1.4.5 and 900.00). The agency and facility management confirm they have been able to manage security issues in a community confinement setting while avoiding more intrusive and potentially traumatic practices of cross-gender searches of any type. Interviews with staff confirm they have been trained how to respectfully search Transgender or Intersex residents. Intake staff confirmed no searches are performed to determine genital status and that strip searches do not occur at LightHouse. Staff knew that transgender or intersex residents should be searched by the gender staff of the individual's preference.

The Auditor finds LightHouse compliant with the standard expectations on limited cross-gender searches or viewing. Staff and residents both confirmed there are no strip searches as a practice and no cross-gender pat searches. The Staff have been provided appropriate training on the search of transgender individuals. The Auditor also confirmed with the residents the agency practice of same-gender staff being present when urine samples are being secured for drug testing. The facility policy, observations of the physical plant, and observations made of staff practice support residents are able to shower, perform bodily functions, and get change without opposite gender staff seeing them.

Residents' support staff provide appropriate notice before entering the bedroom or bathroom areas. The Auditor finds that the standard has been exceeded. All elements required have been met as discussed above; the Auditor believed LightHouse exceeds the standard by creating an environment in which residents feel safe while removing all strip-searches and cross gender pat searches.

## **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

- ☐ **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.*

#### Policies and written/electronic documentation reviewed.

LightHouse Pre-Audit Questionnaire  
 Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA)  
 Policy 1.1.6 Intake Process  
 Voiance interpretive services  
 Resident Handbook (Large Print)  
 Referral Paperwork/ Intake Paperwork  
 Training records on Voiance use  
 Crisis Services of Buffalo website

#### Individuals interviewed/ observations made.

Vice President for Justice Services  
 Random Staff  
 Random Residents

**Indicator Summary determination.**

**Indicator (a)** Both the PREA Policy (900.00) and the Intake Policy (1.1.6) require the identification of populations who may have difficulty in understanding information. The PREA Policy (pages 6-7) requires facility staff to ensure residents understand, regardless of disability or language barriers, the facility's efforts to maintain a PREA safe environment. This includes how to keep oneself safe, the facility's zero-tolerance stance, how to report a concern, and how to access treatment. As a Reentry facility, admissions come from Federal prisons, with the remaining referred by the regional Federal Probation Office. As a result, LightHouse receives information in advance about residents with significant medical issues/disabilities or other mental health disorders that may impact PREA scoring. The Intake/Release Coordinator sits with each new resident and screens for any missed medical information or other factors that may impair their understanding of the facility rules, including the zero-tolerance policy toward Sexual Abuse and Sexual Harassment. This screening would help identify those who have comprehension or limited reading ability. The Auditor was able to sit in on the Intake of a resident at LightHouse and observe the way the Intake and Release Coordinator provides initial education on PREA as well as the questions being asked as part of the PREA screening process. The PREA Coordinator confirms the agency can provide written materials to clients in various formats and languages as needed. The facility supports individuals with a range of disabilities and has an ADA compliant bedroom and bathroom facility. The Auditor was provided copies of the Resident Handbook in English and Spanish and in large print. The tour showed posting of PREA information in multiple languages and confirmed with the resident they have continual access to PREA information as required in 115.233. The program has TTY for individuals who are deaf. The agency's experience supporting individuals with developmental and intellectual disabilities has positioned itself with resources to support clients with those issues and an ability to provide training specific to working with that clientele. The agency provides programming for these populations in another division of the agency. Residents interviewed with physical and cognitive disabilities confirmed there were staff available with whom they could ask and receive assistance in comprehension or accessing any part of LightHouse's efforts to keep them safe from sexual abuse or sexual harassment.

**Indicator (b).** LightHouse has signage up related to PREA and other important information in both English and Spanish, the most common languages spoken by their population historically. Intake paperwork and handbooks can be translated into multiple languages as needed. The agency has provided access to interpretive services through an online system called Voiance. The system uses telephonic or video interpreters to aid resident and staff communication. The Auditor was able to learn how staff would access the system if needed. Voiance's website supports the service can translate in over 80 languages, including VRI (American Sign language). The Director set up the program for the Auditor use with the ESL residents if needed. Residents acknowledged there were some staff whom they could approach who could aid in their understanding of information. The Auditor confirmed this with random residents and a resident with developmental disabilities. Random staff interviewed acknowledge they cannot use resident interpreters to ask any sensitive information, including PREA related questions. One of the ESL residents confirmed they had received a Spanish Handbook at intake while the other was provided one while the Auditor was on site. The Auditor observed an intake where the resident was asked about language and disability barriers and including the format they would like the handbook in.

**Indicator (c).**

Random staff interviewed confirmed that resident interpreters are not appropriate in any communication about concerns of sexual misconduct. Staff are aware that it is only appropriate to do so in an emergency basis to find out information sufficient to obtain appropriate medical care. Staff were aware of the existence of interpretive services. Training records and materials support the expectation has

been made apparent to staff. Policy 900.00 states, "The use of resident interpreters, resident readers, or other types of resident assistants will not be used, except in limited circumstances, where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-responder duties or the investigation of the resident's allegations. In these exceptions or limited circumstances, documentation of all such cases shall be documented."

### **Compliance Determination**

LightHouse is compliant with the expectations of providing full access to Limited English Proficient (LEP) and disabled residents' ability to benefit from its efforts to prevent, detect, and respond to sexual misconduct. The facility can aid disabled or LEP residents in understanding PREA, how to report a concern, and how to access assistance if one has been a victim. The agency had provided documentation, and the Auditor could see on tour how LEP or disabled individuals could access information. CRJ's experience with individuals with intellectual and developmental disabilities provides an invaluable resource when individuals with these challenges are admitted. Residents' interviews support staff are available if they are having difficulty in understanding. Staff interviews and training documentation further confirms the staff's ability to aid the residents in all aspects of the facility's effort to have a zero-tolerance, PREA safe environment. The Auditor also took into consideration the local rape crisis agency Crisis Services who is also prepared to provide counseling service to all individuals who may have hearing or language barriers. Prominently displayed on their website is the following statement, "Language should never be a barrier to receiving support during a crisis. Our crisis first responders have immediate access to language interpretation. We also are able to serve our Deaf and Hard of Hearing communities through 711 Telecommunications Relay Services. Crisis Services is here for you."

## **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 who may have contact with residents? ☒ Yes ☐ No
- Does the agency consider any incidents of sexual harassment in determining whether 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)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

#### **Policies and written/electronic documentation reviewed.**

LightHouse Pre-Audit Questionnaire  
 Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA)  
 Hiring/Applicant Tracking System  
 Pre-Employment Questionnaire  
 Prior Institutional Employer Inquiry form  
 Employee handbook  
 Human Resources Memo  
 Random Staff Files.  
 Employee Standard of Conduct  
 Personal Touch Catering Background Checks

#### **Individuals interviewed/ observations made.**

Human Resources Director  
 LightHouse Director

**Indicator Summary determination.**

**Indicator (a).** The Community Resources for Justice Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA) page 2 of the policy addresses the definition of sexual abuse consistent with the federal definitions. The policy on page 4 addresses this indicator's requirements. Using language from the standard, the policy strictly prohibits the employment or contracting the services of individuals who have been convicted of engaging or attempting to engage in, or administratively be adjudicated for sexual assault. Upon hire to LightHouse, all employees have signed a form that directly asks if they have engaged in prohibited behaviors. The *PREA Employment Questionnaire uses language consistent with the standard*. This form is also required to be filled out each time an individual is promoted. LightHouse does not currently hire contractors who have regular contact with residents, nor do they have they had any volunteers. Human Resources Staff confirm that individuals with past histories described in indicator a) would not be eligible for employment. Any one-time contractor such as completing service repairs reportedly would be supervised by staff while on-site reportedly. These individuals would also be informed about PREA and the residents' right to be free from sexual abuse or sexual harassment. As a Bureau of Prison funded facility all LightHouse staff are required to sign a Standard of Conduct document which addresses prohibited behaviors with residents including sexual misconduct.

**Indicator (b).** As noted in indicator (a), LightHouse does not contract with individuals who provide direct services to residents. The Human Resources Department for CRJ will review all employees recommended for promotion. It will require the PREA Employee Questionnaire to be completed, followed by a complete Human Resources file review. The Human Resources Director confirmed if the Talent Acquisition Specialist identifies sexual harassment concerns in the staff file, the information would be referred to the Director of Human Resources and the Vice President for Justice Services before a promotional offer would be extended.

**Indicator c).** Community Resources for Justice policy 900.00 states, "CRJ requires that before any new employee, who may have contact with residents, is hired: (1) a criminal background record checks is conducted, and (2) best efforts are made 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." The Auditor was provided information supporting all current employees have had an initial criminal background check. In addition to the policy, background checks are a requirement of the funding source. The agency also has in place a system to make inquiries of prior institutional employees. None of LightHouse's current employees have had prior institutional employment other than individuals who worked at other CRJ facilities previously. The Human Resources Director and the facility Director both committed to the agency's efforts to protect clients through seeking information about previous misconduct. The Agency utilizes a background service to check criminal and employment histories. The service has a PREA specific release they require perspective employees to sign to allow a specific inquiry to past concerns of sexual misconduct. (Prison Rape Elimination Act Questionnaire for Prior Institutional Employers). The Auditor was able to review the content and process map for new employees. As a FBOP site all employees have criminal background checks also completed by the US government.

**Indicator (d).** As noted in indicator (a), LightHouse does not contract with any individual to provide services to the client on-site. Residents seek medical and mental health services in the community. All visitors to the facility are monitored by staff when on site. The facility has one vendor who provided food delivery to the facility daily and only have limited supervised contact with residents The Auditor was

provided with documentation that the Catering Service completes criminal Background Checks on all employees including those who deliver food and supplies to LightHouse.

**Indicator (e).** The Community Resources for Justice Policy 900.00 requires all employees and contractors to undergo a criminal background check every five years. LightHouse has only been open for less than two years and no individual had previously worked for the CRJ organization in any capacity. The Auditor is confident the process was in place to complete the required background checks as the agency is required to submit all employee, contractors, volunteers, and intern to the Federal Bureau of Prisons who complete a criminal background check on all new hires and on all employees at the time of contract renewal which normally occurs every five years. The agency has completed the necessary checks on individuals in their other programs when the contract renewal has gone beyond the 5-year window.

**Indicator (f).** Noted in Indicator (a), all LightHouse employees are asked to complete the PREA Employee Questionnaire. This document asks all prospective employees about the required element in the aforementioned indicator. CRJ had all existing employees complete the form after it was initiated in 2015. The employee signs the form after they read information, including the following: "CRJ shall impose upon employees a continuing affirmative duty to disclose any such misconduct". The Employee Standard of Conduct document also sets forth the requirement that the employee must report any engagement in criminal activity. Staff understood the expectation to report any behavior by themselves or other staff.

**Indicator (g).** The Community Resources for Justice PREA Employee Questionnaire also contains the following passage: "any material omissions regarding such misconduct, or provision of materially false information, shall be grounds for disqualification from employment or termination." Human Resources Director confirmed they have not had to fire any individual at LightHouse for any such inaccuracies related to any sexual misconduct.

**Indicator (h).** CRJ Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA) allows for the agency to disclose to other institutions any PREA related concerns with proper releases of information. The policy states, "CRJ provides 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." Interviews with Human Resources staff confirm they make requests of outside employers when hiring; they report they do not frequently receive similar requests for prior employees. A memo from the Acting Human Resource Director confirmed there have been no request regarding former LightHouse staff in the past year.

### **Compliance Determination**

The Community Resources for Justice is compliant with the hiring and promotion decisions required by PREA. The agency has policies (900.00 and HR hiring policy) in place to address the requirements of the standard, including the screening of individuals for sexual abuse or harassment histories. The agency has all staff working in their Social Justice Services Division undergo criminal background checks. Interviews with the Human Resources Director was completed in November of 2020 as part of another CRJ audit in Boston. The interview also limited any chance of cross exposure between facilities of CRJ. The Auditor received electronic copies of random staff files; the Auditor picked the days before the site visit. The Auditor requested in advance of the on-site visit the following information: dates of hire, original and 5-year background check (if they existed), dates the staff signed acknowledgment on continuing obligation to report the behaviors listed in indicator (a), and if the individual had prior institutional employment. This process allowed the Auditor to select a diverse sample of staff to be

reviewed. During the Pre-audit phase, the Auditor requested documentation of the dates HR elements were completed for at the time all seventeen individuals employed at LightHouse. The Auditor reviewed a sample of 8 of the 17 current staff files matching the hard documentation dated to the previously provided dates. The process allows the Auditor to confirm the hard documentation of selected files against the previously provided dates when he was on-site. Documentation from the personnel files for LightHouse supported this standard's requirements, including asking employees about past sexual misconduct, responsibilities of continuous disclosure, and consequence for omission or falsification of information. Supporting LightHouse's compliance were the policy that agreed with the standard's elements the interview with CRJ Human Resource staff, and the agency PREA Coordinator. The Agency has policies, procedures, and practices in place to support ongoing compliance. The Auditor also considered compliance with the CRJ Employee Handbook, which informs individuals about prohibited behaviors and conduct that can lead to discipline or the termination of employment. Interviews with HR and agency and facility administration further support the needed communication and practices are maintained.

## 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

- ☐ **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.*

### **Policies and written/electronic documentation reviewed.**

LightHouse Pre-Audit Questionnaire

Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA)

### **Individuals interviewed/ observations made.**

PREA Coordinator

Director of Reentry Services

LightHouse Director

LightHouse Assistant Director

### **Indicator Summary determination.**

**Indicator (a).** The Community Resources for Justice bought the Buffalo facility from another previous vendor of the United State Bureau of Prisons. The Agency leadership went through the facility and redesigned the space. The Director of Reentry Services described in detail the steps taken to renovate the space with an eye toward client safety. The agency leadership met with architectural firms and came up with a plan that reduced blind spots and improved client flow and staff supervision. One of the largest changes in LightHouse was the decision to not use the front house for the program. The Assistant Director who worked in the previous agency supported the significant improvements in the physical plant and in the management of the environment. She noted having the program administrators and the case managers in the main building has provided more cohesive management of the resident and allows for these staff to better monitor client movement and interactions while supporting the Program Monitors. Similar to other CRJ program designs the Program Directors and Case Manager's have an office on the upper two housing floors. The landing areas off main staircase also houses office space for the Intake and Release Coordinator and the Community Employment Specialist. The house in the front of the facility is only used for staff meetings and training space currently. The agency has limited the keys to the space to ensure no unauthorized use of the space occurs.

**Indicator (b).** In preparing for the opening of the LightHouse facility the agency put in new camera system. The facility has 43 camera locations monitoring interior and exterior spaces of the complex. The cameras provides staff the ability to monitor the resident movements across the four levels of the facility. The Auditor reviewed the camera from the Program Monitor station which is always staff by one of the two Program Monitor on duty.

### **Compliance Determination**

The Auditor finds the standard to be met. The Director is aware of the importance of assessing physical plant needs as well as monitoring technology to aid supervision across four floors of the facility. She was able to discuss the process for making requests if a need is identified. Agency administration, including Vice President of Justice Services, the PREA Coordinator, and the Director of Reentry Operations all supported that every incident that impacts client safety is assessed to determine if

physical plant changes or monitoring technology could aid in preventing further issues. The Auditor also considered the interview with the Assistant Director who supported not only the physical plant improvements but how the decision to move program administration have positively impacted the safety of the environment.

## 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 evidentially 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? (N/A if agency *always* makes a victim advocate from a rape crisis center available to victims.) ☐ Yes ☐ No ☒ NA
- 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 agency 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? (N/A if agency *always* makes a victim advocate from a rape crisis center available to victims.) ☐ 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.*

#### **Policies and written/electronic documentation reviewed.**

LightHouse Pre-Audit Questionnaire  
Policy 900.00 Staff and Resident Sexual Misconduct  
Police Protocols for evidence collections in sexual assaults.  
2017 MA Adult Sexual Assault Law Enforcement Guidelines  
Letter from Buffalo Police.  
Letter from Crisis Services (CS)  
Letter from Erie County Medical Center confirming SAFE/SANE Services  
Web search of ECMC services  
PREA Signage (English/Spanish)  
NY Department of Health website (SAFE training and SAFE Hospitals)  
Websites of Crisis Services(CS )

#### **Individuals interviewed/ observations made.**

Erie County Medical Center representative  
Discussion with CS staff  
Coordinated response plan visible in the facility.

#### **Summary determination.**

**Indicator (a).** Since opening in 2020 the LightHouse program has had no allegations of sexual abuse and as such has had no need for a investigation by the local police or the need to send a client for a forensic exam. Criminal investigations at LightHouse would be the Buffalo Police Department's responsibility, while administrative investigation would fall under CRJ's purview. LightHouse staff would not be involved in evidence collection but are trained as part of first responder duties to seal off potential crime scenes and instruct potential victims and perpetrators to preserve evidence. The State of New York sets forth the state protocols for the collection of evidence in a rape kit. The state also references the use of the National Protocol for Sexual Assault Medical Forensic Examinations. The New York Department of Public Health also provides the training of all SAFE nurses in the state. The Auditor communicated with the DPH staff about the training and confirmed that the Erie County Medical Center has access to SAFE trained staff. The state's Division of Criminal Justice (DCJ) and the Department of Public Health (DPH) websites each have extensive information on helping victims of

sexual abuse. The DCJ has developed a training video for medical staff on the collection of rape kits called "A Body of Evidence: Using the NYS Sexual Offense Evidence Collection Kit".

**Indicator (b).** LightHouse would not house any youthful adult inmates. The state recommends the use of national protocols developed by the US Department of Justice. There are separate guidelines for the sexual assaults of juveniles and adults. The state guide for SAFE training specifically states "Medical treatment and forensic examination of sexual assault survivors is provided in compliance with all relevant laws and regulations and consistent with generally accepted standards of care, including OVAW's 'A National Protocol for Sexual Assault Medical Forensic Examinations Adults/Adolescents.'" The document goes on to state the interdisciplinary approach to forensic examinations, the expectation of an on-call system for SAFE trained individuals, and the training expectations.

**Indicator (c).** LightHouse has provided documentation in its Coordinated Response Plan, that resident victims, are sent to Erie County Medical Center. The Hospital provided documentation confirming staff nurses who are trained as SANE. The Auditor spoke with hospital representatives as well as confirmed SANE availability at the hospital through the state Department of Public Health website. Through interviews and what the website states, the Auditor confirmed that victims of sexual assault are provided service free of charge. The cost is covered by a 2001 New York state law called the 'Sexual Assault Forensic Exam Payment Act'. If a SANE is not immediately on-site, they can call one in. Policy 900.00 Page 12 sets forth the requirements of using a hospital with SAFE/SANE forensic examiners. Page 14 of the same policy confirms that resident victims are provided services free of charge no matter if they agree to cooperate with an investigation or not. The Auditor was provided with information confirming the relationship between the program and the Erie County Medical Center. The State Website supports there are 4 medical facilities in the region with SANE services including 2 other hospitals in Buffalo.

**Indicator (d)** CRJ has entered into a working relationship with the Crisis Services or CS for short. CS is a regionally leader in providing rape crisis services to victims of sexual abuse. A letter outlines CS's willingness to work with LightHouse. Page 13 of Policy 900.00 Staff and Resident Sexual Misconduct sets forth the agency's responsibility to provide residents with access to a rape crisis agency. There are no current residents accessing services at CS. CS can not only provide crisis services and supportive counseling; it also can provide clinical services to individuals struggling with their victimization history. The Director reports that they can also now provide services utilizing a secure video chat system and they have added a chat feature to their system to allow for safe and confidential communication.

**Indicator (e).** A representative of CS confirmed they provide support for victims of sexual abuse, including support during forensic exams, investigative interviews, on-going support services. The agency confirmed they would aid a resident at LightHouse in finding a support network if they move to another area at the time of release. Hospital Staff confirmed its protocol to offer CS services to victims of sexual assault. The LightHouse's Coordinated Response plan requires the Residential Supervisor or Case Manager on Duty to notify CS to request they come to meet with a victim or to meet the victim at Erie County Medical Center if the client agrees to go for an exam. COVID-19 has impacted some of the efforts to expand resources to the clients onsite at LightHouse. CS has been reportedly able to provide virtual support to victims during a forensic exam. CS would be allowed professional visit status in a non-covid period.

**Indicator (f).** The Auditor was presented with a letter from the Buffalo Police acknowledging the responsibility to investigate sexual assault cases at LightHouse. The letter stated that the case would be referred to the Special Victims Unit who handle sex crimes and that they have understanding of the Prison Rape Elimination Act requirements. The LightHouse Director confirmed she would be the point

of contact if an investigation occurred. The Director was aware of the need to obtain sufficient information to aid any administrative investigation and to ensure proper notifications are made consistent with PREA standards (115.273). The LightHouse Director confirmed the agency has developed a good working relationship with the Buffalo Police Department since opening.

**Indicator (g).** The Auditor is not required to audit this provision

**Indicator (h).** The agency will make a victim advocate available through CS , so the indicator is NA.

**Compliance Determination:** Absent any investigations the Auditor had make compliance determination based on information provided by the facility and through research into the community-based resources available. The Auditor finds LightHouse in compliance with this standard's expectations. Though the facility does not provide many of the services directly covered in the standard, being in Buffalo, the required elements are all found in the community, including SANE services at multiple local Hospitals, a major metropolitan police force with unit dedicated to investigating sex crimes, and an active Rape Crisis Agency. In addition to the interviews, the Auditor found a great deal of information on the state website, which was consistent with the information I received verbally and in document from LightHouse management and the community contacts referenced above. The Auditor took into consideration in determining compliance the random staff knowledge of preserving evidence, the policy, various MOUs with community agencies and the available resources in the community.

## 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 the policy 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

- ☐ **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.*

#### Policies and written/electronic documentation reviewed.

LightHouse Pre-Audit Questionnaire  
Policy 900.00 Staff and Resident Sexual Misconduct

#### Individuals interviewed/ observations made.

Vice President for Social Justice  
Program Director  
Agency PREA Coordinator.

#### Indicator Summary determination.

**Indicator (a).** LightHouse has policies in place to ensure that all reported incidents of sexual abuse or sexual harassment are investigated. Policy 900.00 states, "program staff must report all allegations of sexual abuse or sexual harassment, including third-party and anonymous reports, to the local authorities and all contracting agencies for further investigation" (page16). Interview with staff confirmed they must report all allegations of sexual assault or sexual harassment no matter the source or if they think the allegation is true or not to the Program Director. The staff also were able to describe the

process of protecting evidence and documenting the incident. Agency response plans also ensure all allegations are investigated. Interview with the Vice President for Justice Services confirms the expectation, and she reports the agency will involve the PREA Coordinator and other leading individuals in the organization to make sure a thorough review occurs in a timely fashion.

**Indicator (b).** As noted in indicator (a) the LightHouse and Community Resources for Justice policy requires all criminal investigations be referred to the local police and funding sources that are part of federal or state penal systems. CRJ would ensure that non-criminal acts would be investigated internally. The agency has provided the training records of 4 individuals who would complete administrative investigations in the Special Investigative training standard. The CRJ policy is available on the Agency website. The Agency PREA Coordinator receives information on all allegations and both he and the LightHouse Director would document the referrals to any outside investigative body. The LightHouse Director or the Director of Reentry Operations would ensure the funding source would also be made aware immediately.

**Indicator (c).** Policy 900.00 requires a referral of criminal acts to the local authorities who have the authority to investigate crimes at LightHouse. The letter of agreement from the Buffalo Police Department ensures that any PREA related crime at LightHouse will be referred to the criminal investigative unit that investigates sex crimes in the city. The Assistant Director of LightHouse, who is one of the agency's trained investigators, confirmed the facility would ensure the police investigative officer is aware of the federal requirements on victim notification in PREA. He also reports there would be an expectation to set up regular calls to review the progress of the case. The Assistant Director also confirmed that if an administrative investigation found information that may support a criminal finding there would be immediate notification to the police.

**Indicator (d).** The Auditor is not required to audit this provision.

**Indicator (e).** The Auditor is not required to audit this provision.

#### **Compliance Determination**

The Auditor finds that the facility has in place trained staff, who know all allegations must be referred for investigation and how to protect evidence. The facility has four staff associated with the program trained to complete administrative investigations (115.234). The Agency also has provided evidence to support the Buffalo police department is ready and willing to provide criminal investigative services with individuals from its sexual crimes' unit. Finally, the agency in standard 115.221 provided evidence of access to trained forensic examiners at the Erie County Medical Center. Interviews, documents provided, and the information stated here support a finding of compliance for this standard.

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

- ☐ **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.*

#### Policies and written/electronic documentation reviewed.

LightHouse Pre-Audit Questionnaire  
Policy 900.00 Staff and Resident Sexual Misconduct  
Training Records  
Employee sign signature for trainings  
NIC and CRJ PREA Courses  
CRJ Course evaluations

#### Individuals interviewed/ observations made.

PREA Coordinator  
LightHouse Director  
Random Staff

#### Indicator Summary determination.

**Indicator (a).** The staff of LightHouse are trained using the same curriculum that other CRJ facilities use. During COVID-19, the new staff received the training virtually from the Agency PREA Coordinator. The Auditor was able to read evaluations from the training stating it was informative and engaging. A review of the PowerPoint presentation and the accompanying exercises shows the 10 topics required



were addressed. The topics included 1) a zero-tolerance policy for sexual abuse and sexual harassment 2) the duty to protect, detect and respond to incidents of Sexual Assault or Sexual Harassment 3) the residents right to be free from abuse 4) both the staff and resident right to make a report without fear of reprisal 5) the dynamics of Sexual Abuse in institutions 6) signs and symptoms of a victim of sexual abuse 7) how to act in response to a disclosure of Sexual Assault 8) How to avoid inappropriate situations with residents 9) How to effectively communicate with LGBTI and gender non-conforming residents and 10) what are mandated reporting requirements. Random staff Interviewed were able to give examples of the various elements of the training. In addition to being able to recount the content of the training, the staff confirmed the frequency of the PREA training. They reported additional related training are made available online or provided in a classroom setting, including a separate class on Professional Boundaries and working with LGBTI populations. The Auditor was also provided Policy 900.00 (page 5), which specifically requires the training to cover the elements described in this indicator.

**Indicator (b).** The PREA training for staff at CRJ addresses how both male and female victims may react and why each gender may engage in sexual misconduct. The Director confirms that if staff came from a single-gender facility, the employee would be reoriented to working in the co-correctional LightHouse. None of the current staff had transferred in from CRJ's other programs. Policy 900.00 (page 5) sets forth the training to address the gender-specific issues for the population the employee works with. The further policy states additional training will be provided when a staff person is reassigned to a different gender environment than they had previously worked. In addition to formalized PREA training staff have access to other related coursework. In the review of staff records, there were cultural competency courses, a Boundaries and diversity course, as well as training on motivational interviewing and training on working with victims of sexual abuse.

**Indicator (c).** LightHouse employees are all trained in the ten items required in indicator (a) upon hire and at a minimum of every other year. CRJ staff participates in other PREA related topics at a minimum of once per year. Because of COVID-19 the employees who were in their second year took the National Institute of Corrections course "PREA – What you need to know." CRJ also provided annual training on searches, ethics, boundaries, and working with diverse populations as noted in indicator (b). Staff interviewed supported that PREA training and related topics occur two or more times per year. Training records were provided to the Auditor to support the ongoing training has happened in addition to the file reviews. The Bureau of Prisons periodically provides training on professional boundaries to staff at Reentry facilities.

**Indicator (d).** Employees complete onsite training in which the training form states the following "By signing this training roster, we hereby acknowledge that we understood the material presented" Additional training courses such as those provided through the National Institution of Corrections have a score showing the individuals rate of comprehension of the materials presented. The Agency PREA training completed remotely has also included a test to ensure the material is understood.

### **Compliance Determination**

The Auditor find the LightHouse is compliant with the requirements of this standard. Compliance is based on the materials presented relating to the training consistent with indicator (a). The agency provided documentation of all employee's original PREA training and ongoing training in the form of training rosters, NIC certificates, and Human Resource records. Training dates were provided for all employees who were hired at LightHouse in the last two years. The full training records for all 18 individuals who were employed during 2020 was also provided. The Auditor was able to review the training documentation of all existing staff and of the new hires. In addition to formal PREA training, the facility provided other related training to reinforce PREA training information. It should be noted CRJ

was responsive to the ongoing COVID-19 pandemic by providing virtual training opportunities in what is normally provided in a classroom experience. The final factor given consideration in determining compliance was the random staff interviews. Staff spoken with were able to relate the information they learned as part of the agency training, including examples of all ten elements covered in the indicator (a). The staff reported to the Auditor the training was effective; this was evident by the knowledge staff were able to relate back information to the Auditor.

## 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

*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.*

**Policies and written/electronic documentation reviewed.**

LightHouse Pre-Audit Questionnaire

Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA)

PREA Training PowerPoint

Documentation of Contractor education

Contractor/ Visitor log showing PREA information provided

**Individuals interviewed/ observations made.**

Facility Director

Sign-in logs at the front desk

**Summary determination.**

**Indicator (a).** LightHouse does not contract for an individual to provide direct services to their residents. Because of COVID there has been no interns in over a year and there is no volunteers currently. Policy 900.00 (page 6) sets forth that all individuals who have contact with residents have some level of education on the agency's Zero tolerance expectation and the efforts to prevent, detect and respond to sexual assault and sexual harassment claims.

The facility Director confirms that when the facility has volunteers with routine resident contact, they must meet with an administrator for PREA education. Visitors who are one time or not routine are provided the PREA brochure which tells them about PREA and ways to report concerns. The Auditor was provided this same material upon entry to the facility. I requested the brochure in Spanish and the staff were able to provide that copy also. There is a process for documentation of one-time visitor's receipt of PREA brochures, but examples of the practice had been impacted by COVID-19 safety protocols that reduce access for any outside individuals.

**Indicator (b).** Page 6 of CRJ's Policy 900.00 states, "All volunteers and contractors shall have at least been notified of the agency's zero-tolerance stance regarding sexual abuse and sexual harassment and informed how to report such incidents." The Director reports and material presented confirmed that one-time visitors like the Auditor are given a PREA Brochure upon entry as part of the signing in process. Individuals providing more frequent visits who have contact with residents get a more formal discussion about PREA with an administrator. When they have interns, the individuals receive the full PREA training course like any new employee.

**Indicator (c).** All visitors are required to be registered at the front desk. Documents were provided that all contractors are provided information about PREA. The facility administration educates volunteers who provide services on PREA. Policy 900.00 page 6 states, "The program shall maintain documentation confirming that volunteers and contractors understand the training they have received." Due to COVID-19 there are no Interns in the facility.

**Compliance Determination**

In policy 900.00, Community Resource for Justice addresses the standard language expectations. The facility does not employ any contracted staff that provide services to the clients of LightHouse. The facility had a food service contractor who drops food off at the front desk but does not go further into the facility normally. The Auditor was also able to see firsthand the process visitors are informed on residents' rights to sexual safety. The Director confirmed the dates in which the facility has been closed to outside visitors to protect residents from COVID-19 exposure. As a result, there is limited documentation to be reviewed. Absent any contracted staff, the information provided to the Auditor, staff knowledge of the normal practice, and the interviews all support a determination of compliance.

## 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

*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.*

### Policies and written/electronic documentation reviewed.

LightHouse Pre-Audit Questionnaire

Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA)

Policy 1.1.6 Intake Process

Client files

### Individuals interviewed/ observations made.

Random Resident

Targeted Residents

### Summary determination.

**Indicator (a).** Agency policy and LightHouse practice support all residents are provided PREA Education upon admission. They are educated on the client handbook, including PREA information, the facility's Zero Tolerance for sexual misconduct, and a PREA Brochure. The Intake and Release Coordinator has the residents sign for the education they receive. The forms can be provided in multiple languages. The Auditor was provided a Resident handbook, PREA brochure, and the PREA education acknowledgment form in English and Spanish, the two most common languages spoken. Resident interviews support they know several ways they could report PREA concerns, that they would be protected from retaliation, and that being free from abuse is their right. Policy 900.00 provides specific information on the content of resident education, and residents support they are provided information about PREA in the first hours in the facility. Within three days after the initial intake, the

facility case management staff provides full orientation to the program, including a second review of the PREA information.

**Indicator (b).** The LightHouse facility does not routinely receive or transfer residents to or from other CRJ facilities. Most residents have had Prior education about PREA in other state or county correctional centers. According to the Intake and Release Coordinator, LightHouse's education occurs no matter where the individual is coming from, be it the community, a correctional center, or another CRJ program.

**Indicator (c).** The Auditor received PREA materials in 2 languages. The facility has audio translation services (VOIANCE) to aid limited English proficient and a TTY for those with a hearing disability. Individuals with visual impairments can get larger print materials. A resident with a cognitive disability confirmed there are enough staff available that someone can help you if you have trouble reading. Policy 900.00 requires "These residents (LEP and Disabled) are provided equal opportunities to participate in or benefit from all aspects of CRJ's efforts to prevent, detect, and respond to sexual abuse and sexual harassment."

**Indicator (d).** Each resident's PREA Intake Orientation Sheet is signed and dated by the resident in a paper format that is then placed in their file. The Auditor reviewed a sample of twenty current and prior resident's forms. Resident interviews randomly confirmed the orientation process does occur in most cases within the first 24 hours of their admission.

**Indicator (e).** The Auditor confirmed that residents had handbooks, brochures, and postings (English and Spanish) about PREA and how to report a concern on each level of the facility. Resident interviews support they were aware of the information even if they said they were not worried about PREA.

### **Compliance Determination**

The Auditor has determined LightHouse is meeting the standard expectation in policy, practice, and documentation. The random resident interviews supported all residents of LightHouse are provided education related to PREA. Resident interviews supported they know the zero-tolerance expectation toward sexual abuse or sexual harassment. The random residents confirmed that intake staff also educated them on how to report a concern and community-based services for those with victimization histories. Residents confirmed they did receive the information in a timely basis upon arrival. Two policies, Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA) (pages 6-7) and Policy 1.1.6 Intake Process (pages 1-2), address the requirements of education of residents on PREA. Materials are available in more than one language, and the staff were aware of the translation services available. Residents support they understand their rights under PREA and know where to turn for information if needed. The Auditor also considered the documents found in client files consistent with policies supporting PREA education has occurred in determining compliance.

## **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 receive 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

*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.*

**Policies and written/electronic documentation reviewed.**

LightHouse Pre-Audit Questionnaire

Reviewed the NIC training on Investigating Sexual Assaults in a Correctional setting

Certificates of CRJ staff who have completed the training

**Individuals interviewed/ observations made.**

Staff trained investigating sexual assault or sexual harassment claims

**Summary determination.**

**Indicator (a).** LightHouse and CRJ would not be responsible for completing criminal investigations. The Buffalo Police Department would have the primary responsibility for completing criminal investigations at LightHouse. The funding source and referring authority of the clients involved will be informed of any PREA related investigations. The agency has trained ten staff in completing an administrative investigation in a reentry facility. The agency has used the NIC training on investigating sexual assault in a confinement setting.

**Indicator (b).** The NIC training provides the individual with the required content of the standard indicator. The information includes interviewing techniques with victims of sexual abuse, how to provide a Garrity or Miranda warnings, the importance of sexual abuse evidence collection in a confinement setting, and the factors used in substantiating a finding in an administrative or criminal case. The Auditor reviewed the NIC course to ensure the course content met the standards obligations. As a private agency Garrity does not apply, and the agency staff would only be responsible for conducting an administrative investigation. Investigative staff interviewed were aware if an administrative investigation unveiled a potentially criminal act, the event is immediately referred to the police. The investigative staff are aware of the importance of working communication with the local police to ensure the administrative investigation does not impede the criminal investigation.

**Indicator (c).** The Community Resources for Justice has provided the Auditor with the certificates supporting the training of investigators. The Agency has 10 staff who have completed the training, and the Auditor reviewed the certificates (Investigating Sexual Assault in a Confinement Setting) of the 4 individuals most likely involved in a PREA investigation at LightHouse. The Auditor's interview with the Assistant Director who is trained in investigation support they understand key aspects of the training related to indicator b). The investigators from CRJ would only be responsible for completing an administrative investigation of staff misconduct or investigations of client-on-client incidents that are clearly not criminal in nature. There is also the potential that the Federal Bureau of Prisons may also complete an investigation into sexual offenses at LightHouse.

**Indicator (d).** The Auditor is not required to audit this provision.

**Compliance Determination**

The Auditor finds LightHouse compliant with the standard requirements. In determining compliance, the Auditor took into consideration the materials provided in the NIC course. The Auditor also used the certificates provided as proof of training. The Auditor considered the interviews with the Facility Director, Assistant Director, Director of Reentry Operations and the agency's PREA Coordinator, all

who received the NIC training. The Director of Reentry Operations is a former metropolitan police Detective with over 20 years of law enforcement and an internal resource for the facility leadership on investigative practices. Absent any criminal investigations. The Auditor relied on agency policy, the NIC training materials, and the staff interviewed knowledge of the agency investigator in determining compliance. The investigator understood the importance of preserving evidence, how to communicate with victims of recent trauma, how communication with the Buffalo police would be maintained, and how to determine a finding.

## **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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)  
☐ Yes ☐ No ☒ NA
- 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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☐ Yes ☐ No ☒ NA
- 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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☐ Yes ☐ No ☒ NA
- 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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)  
☐ Yes ☐ No ☒ NA

### **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 does not employ medical staff or the medical staff employed by the agency 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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☐ Yes ☐ No ☒ NA

#### 115.235 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners employed by the agency.) ☐ Yes ☐ No ☒ NA
- 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 if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.) ☐ 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.*

#### Policies and written/electronic documentation reviewed.

LightHouse Pre-Audit Questionnaire

#### Individuals interviewed/ observations made.

None

#### Indicator Summary determination.

**Indicator (a).** The indicator is NA. LightHouse does not employ any medical or mental health staff.

**Indicator (b).** The indicator is NA. LightHouse does not employ any medical or mental health staff.

**Indicator (c).** The indicator is NA. LightHouse does not employ any medical or mental health staff.

**Indicator (d).** The indicator is NA. LightHouse does not employ any medical or mental health staff.

## Compliance Determination

All indicators do not apply as LightHouse does not employ any medical or mental health staff. The Auditor confirmed with the facility Director that residents can access the required services in the area. The Auditor also attempted to speak with a variety of community agencies in determining compliance. Hospital staff confirmed the capacity of client victim's receiving follow up services at the hospital and when needed referrals to specialist. The Erie County Medical Center has SAFE trained hospital staff who can provided SAFE/SANE services in the event of a sexual abuse. The Erie County Medical Center is one of three hospital in the county with SAFE/SANE services.

## 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*)
- ☒ **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.*

#### Policies and written/electronic documentation reviewed.

LightHouse Pre-Audit Questionnaire  
Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA)  
Policy 1.1.6 Intake Process  
LightHouse case files  
LightHouse case notes

#### Individuals interviewed/ observations made.

PREA Coordinator  
PREA Manager  
Intake and Release Coordinator

#### **Indicator Summary determination.**

**Indicator (a).** All residence admitted to LightHouse are direct admissions from the community or federal correctional centers. Transfer within the CRJ system would be rare and require the approval of FBOP the funding source. Policy 900.00 requires all admissions to be screened upon admission. "All residents arriving at the program shall be assessed during an intake screening (and upon transfer to another facility) for their risk of being sexually abused by other residents or sexually abusive toward other residents, using the PREA Possible Victim/Predator Screening and Scoring Checklist." The Auditor reviewed files of 10 clients admitted in one year prior and file of 10 current admissions. All files reviewed confirmed that the clients were screened at admission on their risk of victimization or perpetrating behaviors.

**Indicator (b).** The Auditor reviewed admissions over the previous year. All files reviewed showed screenings were completed in the first 48 hours after the resident was admitted. Residents interviewed confirm they meet with the intake coordinator who asked questions related to PREA consistent with the required element. Resident report a clear understanding of PREA and related prior education provided during their stay in federal correctional centers.

**Indicator (c).** The PREA screening tool used in all CRJ facilities is broken into two sections, one looking at victimization potential and the other looking at predatory behaviors. All residents are scored with the designation as either a known victim, a potential victim, or a non-victim. Similarly, all residents are given a designation as a known predator, a potential predator, or a non-predator. The Auditor reviewed with the Intake and Release Coordinator the process by which the tool is completed. During the screening process, residents are asked a series of questions that cover the standard's requirements. Depending on the resident's answers, direct observation and information obtained through the file, the screener scores each category either yes or no. Utilizing the number of yes answers in each section determines the resident's level of risk of being a victim or perpetrator of sexual violence. Information from the scoring is then used to determine the most appropriate housing given the current population makeup, offer referrals for treatment, and when approve for work the treatment team will consider how scoring might impact vocational opportunities.

**Indicator (d).** The Intake and Release Coordinator confirmed, consistent with policy 900.00 and the CRJ screening tool, elements of indicator d) are all considered in determining a score. The following elements are included: if the resident has been a prior victim of rape or sexual assault in an institution, if they are significantly younger or older than the current population, if the physical stature of the individual is smaller than the average population, if the individual has any developmental or mental health issues, if the resident is (or is perceived to be) LGBT or gender non-conforming, has a prior history of sexual abuse, has a prior history of engaging in sexual acts in prison, has a history of protective custody and finally, if the resident perceives that she would be at risk in the institution. During the fall of 2020, the Agency identified an older version of the screening tool utilized in some admissions failed to include one element. This was corrected and the current population records reflect all elements used in identifying potential residents at risk. The Agency PREA Coordinator completed a retraining on screening and utilizing the scores for all intake and case management staff in the Agency during the late fall of 2020.



**Indicator (e).** The PREA Screening tool also looks for predatory factors, including a history of predatory sexual behaviors in prison, a history of physical or sexual abuse toward adults or children, a current gang affiliation, a history of consensual sex in institutions, and a history of violent criminal behavior.

**Indicator (f).** Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA) sets forth on page 8, requiring all residents are reassessed within 30 days. At LightHouse, the Intake and Release Coordinator does both the initial and reassessments of all residents. The reassessments are completed with the assistance of information obtained by the case management staff. Weekly case review team meetings allow for additional information be communicated about the client's progress in the environment. Case management staff routinely ask residents about their perception of safety which is documented in the Secure Manage casefile.

**Indicator (g).** The PREA Coordinator, facility administrators, and the Intake and Release Coordinator are aware that reassessments should occur whenever appropriate information is obtained that might impact a resident's scoring. Reasons for additional screenings can be new information that has been obtained supporting aggressive or victimization histories, behavioral observations, or actual incidents related to sexual abuse or sexual harassment in the facility. Though there have not been any situations where additional Information or client behaviors have required any additional reassessments screening staff and case management staff spoken with were aware of when to preform reassessments.

**Indicator (h).** The Auditor confirmed with an Intake and Release Coordinator that at no time would residents be disciplined for failing to answer questions related to their physical or mental disabilities, their victimization history, their sexuality, or being perceived as LGBTI. Policy 900.00 also states (on page 8) that residents' failure to answer or to disclose the aforementioned topics would not result in discipline. Residents interviewed also felt they would not be punished for being less than accurate about their prior abuse history. Agency has provided staff with additional information on how to ask questions of residents including their sexual orientation and victimization histories.

**Indicator (i).** The Auditor confirmed through interviews with the PREA Coordinator and the Intake and Release Coordinator that PREA sensitive information used in the scoring process is kept confidential. The Intake and Release Coordinator, Program Director and Assistant Director, are the individuals with access to a client's scoring reasoning. Residential Counselors would not have access to anything more than the resident's scoring classification to ensure known or potential victims are kept from know or potential aggressors.

## **Compliance Determination**

The Auditor found the standard to be in compliance with expectations. This conclusion was made based on a review of 20 client files at LightHouse, including former and current clients. The screening instrument provided an objective scoring process, and the individuals charged with administering it were consistent with the policy on the description of scoring and security of information. The Auditor reviewed case files to confirm the screenings' timeliness and confirmed the screening process was applied consistent with the described procedures. The agency had retrained staff in late 2020 on screening tools use after determining one element was not specifically addressed. As a result of the interview with staff, trainings completed, completed scoring forms, and interviews with residents that support screening and reassessments occur, the Auditor has determined compliance.

## 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? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) ☒ Yes ☐ No ☐ NA
- 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? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) ☒ Yes ☐ No ☐ NA
- 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? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) ☒ 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.*

**Policies and written/electronic documentation reviewed.**

LightHouse Pre-Audit Questionnaire

Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA)

Policy 1.1.6 Intake Process

Resident casefiles

**Individuals interviewed/ observations made.**

Facility Director

PREA Coordinator

Intake and Release Coordinator

Random Residents

Random Staff

**Summary determination.**

**Indicator (a).** The LightHouse administration uses the PREA Screening information to inform housing/ bed assignments and recommendations for treatment or vocational decisions. LightHouse does not provide any educational services. The facility uses screening information to identify which bedroom is most appropriate for the resident. The facility will not put known or potential victims in the same sleeping space as those who are known or potential perpetrators of sexual violence. As the program has multiple floors, residents can be provided further separations in the open environment. Residents with prior histories of sexual violence may be required to attend specific treatment if required by the referring authority. Case management staff and employment staff will use screening information to ensure victims and perpetrators are not employed at the same location. Agency policy 900.00 states, "The program uses information from the PREA Possible Victim/Predator Screening and Scoring Checklist to inform housing, bed, work, education, and program assignments with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive. The program makes individualized determinations about how to ensure the safety of each resident."

**Indicator (b).** LightHouse's Intake and Release Coordinator is responsible for utilizing the screening information to provide the most appropriate housing in each population. The screening instrument helps identify parameters that ensure potential victims are not housed with individuals prone to perpetration. Residents can be moved when needed to ensure the most comfortable setting is possible. All moves of rooms would be approved through facility leadership, who would have knowledge of risk screening results. If needed, the facility can create single room only situations that could be used in transgender or intersex residents' housing. As noted in indicator (a) policy, 900 sets forth an expectation of individualized planning based on individual residents' needs. With different housing floors and rules preventing residents from going in other rooms, the facility can keep separate individuals who may be likely victims from those with aggressive histories or histories of engaging in sexual relationships in an institution.

**Indicator (c).** Policy 900.00 states, "The program makes housing and program assignments for transgender or intersex residents in the facility on a case-by-case basis considering whether a placement would ensure the resident's health and safety, and whether the placement would present management or security problems." In the past three years, the facility has housed one transgender

individuals. Records and staff interviews support the individuals was housed consistent with their preference. Discussions with agency and facility leaderships confirm that they have considered how to handle a transgender or intersex resident referral. If the individual is known at the time of referral as being transgender or intersex discussions can be had to understand the residents housing needs/request in previous institutional settings. The Auditor spoke with a individual who described themselves as gender fluid. This individual reported they were housed consistent with how they wanted to be perceived in the house. The Intake and Release Coordinator confirmed as a Reentry facility, they receive information on the clients in the referral packet.

**Indicator (d).** Transgender and intersex residents entering LightHouse would be asked about their feelings of safety and where they would feel more comfortable being housed. Page 8 of Policy 900.00 states, "A transgender or intersex resident's own views with respect to his or her (if applicable) own safety shall be given serious consideration." CRJ and LightHouse management staff confirmed that a short time after admission, transgender or intersex residents would be met with to discuss their needs as it relates to providing a comfortable setting from which they can participate in the program. It was reported the facility met with the transgender clients individually to determine what was needed to support their feeling safe in the environment both before placement and in the first days after arrival. The facility has not had a transgender individual in the past year. The facility described different steps taken to accommodate both the individuals disability and their needs as a transgender individual. The Auditor recommended the agency become familiar with area support groups for the LGBTI community.

**Indicator (e).** Transgender or intersex residents referred to LightHouse would be housed in one of the smaller rooms to provide the most significant privacy level. The facility population allows flexibility to accommodate residents with ADA needs as well as transgender. The ADA bedroom on the first floor with its own bathroom. The facility also has a small four-person female rooms on the first floor also with its own single use bathroom. Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA) (page 9) ensure the resident's ability to shower and change by themselves. Policy states, "transgender and intersex residents will be given the opportunity to shower separately from other residents."

**Indicator (f).** LightHouse does not use an individual's LGBTI status as a mechanism to place all similar status individuals together. There is no state law in New York requiring the housing of LGBTI individuals together. Policy 900 0.00 prohibits this practice (page 8), "The placement of lesbian, gay, bisexual, transgender, or intersex residents in dedicated units, or wings solely on the basis of such identification or status, (unless such placement is in a dedicated unit or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such residents) is prohibited." LGBTI residents confirm that they are not housed based on their identification. Random staff interviews and Interview with the Intake and Release Coordinator who assigns rooms also support that LGBTI clients are not segregated from the population. The Auditor also looked at room assignments in the current population vs. those individuals identified in the population.

## **Compliance Determination**

Compliance determination is based on policy language, interviews with screening staff, and case files review. In determining compliance in indicator (f), random staff and residents who identify as LGBT confirmed inappropriate housing practices were not utilized. The facility did not currently house any transgender or intersex residents; as such, interviews with these populations could not occur. Interview with the LightHouse Director supports they utilize the screening information to protect all residents from sexual assault or sexual harassment. Interviews confirm there are weekly case management review meetings where key elements of the screening information or observations of the client's behaviors in

the environment are discussed if it impacts screening results. File reviews support screening information is used for housing (including bed assignments), treatment referrals, and employment search when appropriate. If there is a conflict between residents, the Auditor confirmed, bed reassignments must be made by the Director, Assistant Director or the Intake and Release Coordinator. This process ensures victims and perpetrators are not together and ensures information about client dynamics learned in weekly case reviews are also considered. The Auditor has made suggested improvements in documentation to ensure elements around treatment and work are documented in a more consistent process in the client file. In determining compliance, the Auditor relied on the facility's thought process for handling future transgender residents, interviews with current residents and staff, and the agency and facilities administration stated expectations.

## 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*)
- ☒ **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.*

#### Policies and written/electronic documentation reviewed.

LightHouse Pre-Audit Questionnaire  
Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA)  
PREA Posters  
Lighthouse Handbook

#### Individuals interviewed/ observations made.

PREA Coordinator  
LightHouse Director  
Phone call with FBOP Regional staff  
Postings up in the facility

#### Indicator Summary determination.

**Indicator (a).** The Community Resources for Justice and the LightHouse facility provide the residents with multiple ways to report sexual harassment, sexual abuse, retaliation, or the neglectful acts of staff that could contribute to such harassment or abuse. Policy 900.00 (page 15) utilizes the standard indicator's language setting forth the expectation. Facility brochures, posters, and residents confirm they can tell any staff person, any facility administrator, or the Agency PREA Coordinator. The Auditor confirmed with both resident and staff in interviews on the multiple internal ways an individual may report a concern. Residents were able to give multiple examples, knew they could make anonymous reports, and make reports on behalf of other residents. The Auditor also tested the agency's reporting system noted on their website for making complaints to the agency PREA Coordinator, which could include anonymous or third-party reports.

#### Indicator (b).



Historically the agency had used a local advocacy organization as an alternative reporting resource. During the Audit of another CRJ facility, the Auditor reviewed with the PREA Coordinator the frequently asked questions (FAQ) from the PREA Resource Center as a potential concern. LightHouse modified its option for reporting a concern to the Office of the Inspector General. This USDOJ Office reviews concerns at FBOP facilities. Any complaints to the OIG would be forwarded to the Regional FBO Office who would inform the facility of the allegation. Though the information is posted up in the facility, The Auditor has suggested clarifying the process further in the resident handbook.

**Indicator (c).** Policy 900.00 requires all staff to accept a report of sexual abuse, sexual harassment, or concerns of retaliation from any resident or third-party and to report them to the supervisor and document the information. Interviews with random staff confirm that they know they must receive and document an allegation of sexual misconduct, no matter the source, immediately. They are aware they can go outside the chain of command if the supervisor is alleged to be involved in the misconduct. The staff gave examples of different CRJ senior leadership they would be comfortable approaching, that they could use the online reporting process or call the PREA Coordinator.

**Indicator (d).** CRJ provides the staff of LightHouse multiple ways in which a staff person can report a concern about PREA in the facility. As noted in the previous indicator, staff interviews confirmed they could go outside the chain of command if they felt they needed to without cause. Staff recognized they could report a concern Directly to the LightHouse Director, the agency PREA Coordinator, the Director of Reentry Operations, or to the Human Resources Department.

#### **Compliance Determination**

The standard is compliant. The agency and facility have put in place multiple avenues for staff and residents to report concerns of sexual misconduct. The agency PREA Coordinator also confirmed there were no hotline calls from a resident or third-party individual on the LightHouse. The Auditor also utilized the agency reporting system through its website. The information was provided to the residents to come in alignment with best practices of not utilizing local rape crisis agencies for optional reporting. Interviews with residents, staff, and agency administration support the necessary resources were in place to ensure a timely response. Most residents confirmed they would go to a staff they trust as a primary option if they felt a need to report a concern and believed it would be taken seriously. The final piece supporting compliance was the Auditor's conversation with the Regional FBOP staff who report not complaints to date.

## **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

#### 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.*

#### **Policies and written/electronic documentation reviewed.**

LightHouse Pre-Audit Questionnaire

Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA)

Policy 1.1.8 Resident Grievance and Appeal Process

LightHouse Handbook

#### **Individuals interviewed/ observations made.**

Resident Interview

Staff Interview

Phone calls with the FBOP representatives

#### **Indicator Summary determination.**

**Indicator (a).** This indicator applies to LightHouse. Residents can file a grievance internally to the facility director or as a Federal Bureau of Prison client they may file a grievance form (BP-8) to the Bureau of Prison. The facility has a policy on grievances (policy 1.1.8) in addition to the information provided in the resident handbook that supports the standard on exhaustion of administrative remedies. Policy 900.00 also addresses the requirements of this standard. The Program Director confirmed there have been no PREA related Grievances in the past three years. The Auditor recommends the handbook language and grievance policy be modified to match the language found in Policy 900.00.

**Indicator (b).** Pages 15 and 16 of Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA) provide direction related to residents filing a grievance. The policy states, consistent with the facility grievance policy (1.1.8) that residents are not required to resolve incidents through an informal process. The policy also states there is no time frame in which the PREA related grievance must be filed. Interview with the Facility Director confirms the standards conditions.

**Indicator (c).** Grievances at LightHouse are generally submitted directly to the Facility Director. If the Facility Director is the subject of the grievance, it may be submitted to either an Assistant Director, the Director of Reentry Operations, or the CRJ PREA Coordinator. Both policies acknowledge there is no informal resolution attempt requirement, and the resident handbook (page 6) states there is no time frame requirement for filing a PREA related grievance. As noted in indicator (a) the residents also can file grievances through the FBOP system including to the US Department of Justice's Office of the Inspector General.

**Indicator (d).** LightHouse PREA policy 900.00 addresses the maximum time frames in which a grievance must be resolved. The time frames include an initial response within 7 days with an extension of an additional if notice is given in writing. In discussions with the facility Director it is clear

that grievances, in general, do not take that long to be resolved. Given the short timeframe of the resident stays, (approximately 4 months), the facility looks to resolve concerns in expedited fashion.

**Indicator (e).** Random staff interviewed confirmed that third-party grievances are possible. Staff acknowledged that complaints and/or grievances might be filed by the resident's family members, attorneys, community agencies, or other professionals working with the client. Interviews with residents and staff confirmed there is no formal policy that prohibits a resident from filing a grievance on behalf of another resident or a resident assisting a fellow resident in the preparation of a grievance. Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA) (page 15) also cover the requirements of this indicator. According to this policy, the alleged victim in a third-party grievance has a right to decline the grievance to be processed. The PREA Coordinator confirms there were no grievances filed related to any sexual misconduct or retaliation for prior reporting.

**Indicator (f).** Policy 900.00 (page 16) defines the conditions for emergency grievances related to sexual assault or sexual harassment cases. The policy addresses time frames in which emergency grievances must be responded to, including an initial response within 48 hours and a final resolution within five days. A policy also covers the requirements of determining if the imminent or substantial risk of sexual abuse exists for the client. The grievance procedures are also outlined in the resident handbook (pages 35-77). Any client PREA Grievance will be handled immediately with the Director or Assistant Director who report they will notify the Director of Reentry Operations, the CRJ PREA Coordinator and the funding source.

**Indicator (g).** Language in policy 900.00 (pg.16) states that residents who file a grievance can only be disciplined if, after an investigation, it is determined that the grievance was filed in bad faith. LightHouse has not had any cases in which a PREA grievance was purposefully filed in bad faith. As a result, there is no disciplinary process to review.

### **Compliance Determination**

LightHouse has not had any cases in which a grievance was filed related to PREA, including any third-party grievance complaints. As a result, there are no grievance files to review in determining compliance with the standard. The Auditor relied on interviews with staff, residents, and the Facility Director, along with policy reviews to determine compliance. Staff interviewed were aware that they must accept all grievances, including from a third-party. Residents were aware of their rights under the grievance policy and the related language in PREA policy 900.00. The Facility Director, who oversees the grievance process, was familiar with PREA requirements related to time and response requirements. The stated results of interviews, the information available to residents in their handbook, and policy language confirm compliance expectations. The Auditor also took into consideration that residents are given the option of filing the grievance directly to the Federal Bureau of Prisons.

## **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

*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.*

#### Policies and written/electronic documentation reviewed.

LightHouse Pre-Audit Questionnaire  
Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA)  
PREA Brochure  
Resident Handbook

#### Individuals interviewed/ observations made.

Representative of Crisis Services  
Representative of local Mental Health services provider



PREA Monitor  
Case Manager  
Random residents  
PREA related postings in the facility

### **Indicator Summary determination.**

**Indicator (a).** At LightHouse, residents are provided information on accessing services for individuals who may have been the victim of sexual abuse. These organizations include Crisis Services and local mental health clinics. The residents are provided information in written form as part of their initial packet upon admission. The facility's PREA brochure and the resident Handbook each have information about these organizations. The Auditor also was able to see information posted about these organizations in hallways, common areas, and case management staff offices. Residents of LightHouse have access to a phone on site that is not recorded. Residents may also have cellular phones, which would allow private communication with representatives of these organizations. Residents confirm they can make confidential calls on-site or make arrangements to seek counseling services in the community. They report the staff are helpful to those who are less familiar with the area and will provide you information on how to contact and find local services.

**Indicator (b).** LightHouse residents are made aware of all staff members' duty to report any incident of sexual abuse. Residents of LightHouse have access to unmonitored communication with outside agencies. The Phone system of LightHouse is not monitored. In discussions with a representative of the local mental health service provider, the Auditor confirmed that all individuals who seek treatment are provided notice related to confidentiality limits consistent with state laws. CS , the local rape crisis agency, confirmed the ability to provide confidential support to the resident and provide those support directly at the facility in a non-COVID-19 period, at the agency's offices, or through phone contact with residents. The Crisis Services offices are approximately 1 mile away in the downtown area and the MOU speaks to some direct services provided and the willingness to aid in the referral process as resident prepare to move home. Clients with past sexual or domestic violence histories will be seen at the LightHouse.

**Indicator (c).** The Community Resources for Justice has entered into a relationship with the Crisis Services of Buffalo (CS). Crisis Service 's Executive Director's letter supports they provide comprehensive, free services, including a 24-hour hotline, advocacy, individual and group counseling, and case management. The Auditor confirmed in phone interviews the ability to provided accompaniment services during forensic exams and police interviews of a victim. CS also provides community awareness and prevention services through partnerships and training with organizations and communities.

### **Compliance Determination**

Residents at LightHouse are provided access to outside confidential support services. The residents have access to local mental health services providers that are funded through the FBOP in addition to the services available through the Crisis Services. The agency provided documentation that supported the appropriate relationships required in indicators (a) and (c) exist. Interviews with the LightHouse Director and case management staff confirm how residents can be assisted in making an appointment for counseling. Observation during the tour supported that information about services was available in both English and Spanish. These languages are the two most common languages spoken by residents entering LightHouse. Resident interviews supported victims of sexual abuse could get supportive confidential counseling services in the community or from the 'hotline' (CS). Compliance is based on the materials available, the relationships developed with community providers, and the resident's



knowledge of how to access the resources. Further supporting compliance, residents who could not name the rape crisis agency or the local mental health provider by name were still aware of postings and believed that case management staff would help them access such services if needed. Residents who reported using the community treatment providers confirm they are aware of limits to confidentiality if someone was at risk of abuse in the facility. The Auditor made suggestions on increasing knowledge of CS services for both staff and residents.

## 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

*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.*

### Policies and written/electronic documentation reviewed.

LightHouse Pre-Audit Questionnaire  
Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA)  
Agency Web Site (third party reporting form)  
Brochures for Residents and Visitors on PREA  
Resident Handbook  
Memo on Third Party Reporting

### Individuals interviewed/ observations made.

PREA Coordinator

Facility Director  
FBOP representative  
Resident Interviews  
Staff Interviews  
Visitor sign in process showing the distribution of Brochure on PREA  
Signage posted throughout the facility.

#### **Summary determination.**

Indicator (a). Community Resources for Justice has established systems to receive third-party reports on sexual assaults or sexual harassment. The agency website provides a phone number and Email address, and a printable form to aid in filing a complaint on behalf of a resident. The agency PREA policy 900.00, page 15, states that the program is to distribute information on how to report concerns related to PREA. This is accomplished by distributing brochures on PREA, which provide information on how to report a concern internally to the agency-wide PREA Coordinator. Residents are also provided information on how to report a concern related to PREA in their handbook and postings in the facility. The random residents interviewed supported they could make a complaint on behalf of a peer if they were too fearful for some reason. They also reported confidence that if a family member called on their behalf the situation would be investigated. Residents also were aware they could make reports through the CRJ website, outside agencies, or their Probation officer. The Inspector General's Office is another avenue for FBOP clients to report a concern. Staff interviewed were aware that all third-party complaints needed to be taken seriously and referred immediately to the Facility Director and the Agency PREA Coordinator.

#### **Conclusions:**

The LightHouse and Community Resources for Justice have successfully provided multiple means for residents and other interested parties to make a PREA complaint as a third party. The information is publicly available on their website and is provided to visitors as they enter the facility in brochures and postings. The facility has trained the LightHouse staff on the need to accept all complaints no matter the source and refer them so they can be investigated. Interview with staff and residents support the policy 900.00 expectations are understood. The Facility Director, random staff and the agency PREA Coordinator all reported not having received any third party PREA related complaints in the past year. The Auditor also went as far as to test the third-party reporting system by sending an email to the address listed on the website. Compliance is based on all the factors listed here, which support multiple avenues to report a concern about Sexual Harassment or Sexual Assault.

## **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

*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.*

**Policies and written/electronic documentation reviewed.**

LightHouse Pre-Audit Questionnaire  
Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA)  
Staff PREA Training materials  
New York Office of the Aging website on reporting requirements of elder abuse

**Individuals interviewed/ observations made.**

CRJ PREA Coordinator  
LightHouse Assistant Director  
Random Staff  
Community Mental Health provider

**Indicator Summary determination.**

**Indicator (a).** Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA) requires repeatedly the immediate reporting of sexual abuse and sexual harassment claims, retaliation and staff actions that may have contributed to such behaviors. Page 16 of the policy state "Reporting Duties a. Any staff must immediately report to the Program Director or designee, any knowledge, suspicion, or information regarding: (1) an incident of sexual abuse or sexual harassment that occurred in the program; (2) retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment; (3) any staff neglect or violation of responsibilities that may have contributed to such an incident or retaliation". The policy goes on to state, (page 17) "Upon receiving an allegation that a resident was sexually abused while residing at the program, the staff receiving this information must immediately notify the Program Director or designee, the SJS Deputy and the SJS Department Director". The policy goes on to address the reporting of disclosure of abuse that occurred in previous institutions and the duty to report retaliation incident and incidents where staff duties may have contributed to abuse occurring. In random interviews, staff consistently reported they understood their responsibility to report in the areas described in indicator (a). The staff knew they must report all allegations of sexual assault or sexual harassment no matter the source of the allegation or even if they had questions on the validity of the allegations. The policy also requires the Program Director to notify the local authorities to begin the criminal investigation.

**Indicator (b).** Policy 900.00 (pg.18) requires the staff to keep confidential any PREA disclosure except to agency administrators and supervisors to facilitate treatment. Policy states, "Apart from reporting to designated supervisors or agency officials, staff shall not reveal 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." Staff in random interviews repeatedly confirmed their awareness of the importance of protecting the victim and the investigative process by limiting the disclosure to those with a need to know. They were also aware of documenting the incident on email or written document to their supervisor but not to put it in the electronic case management system where others could read.

**Indicator (c).** LightHouse does not employ staff in medical or mental health services. Clients would potentially be referred to the Federal Bureau of Prisons (FBOP) contracted Mental Health provider or to

the Crisis Services of Buffalo. LightHouse residents go to counseling paid for by the FBOP or are allowed to continue with their prior service provider according to one US Probation client. Residents spoken with acknowledged that the work with these individuals/agencies would be confidential except if someone was at risk to themselves or others. The mental health contracts are not through CRJ but through the FBOP directly.

**Indicator (d).** LightHouse would not receive a resident under the age of 18. Staff are trained in mandatory reporting laws, and the local police could apply additional charges to crimes against these protected populations. The state of New York website confirms that residents over the age of 60 and those with disabilities have special protection under the law from sexual abuse. These crimes can be reported to local police, specific state agencies or the Attorney General's office for the state of NY.

### **Compliance Determination**

The Auditor concludes the standard is compliant based on training materials, policy, and interviews completed. Since there were no sexual assaults, investigative file reviews and direct interviews of victims or first responders were not possible. The Auditor spoke with the Facility Director, the CRJ PREA Coordinator, and random staff. The Auditor concludes that policy addresses for staff the need to report all incidents of Sexual Assault or Sexual Harassment while protecting the resident victim's privacy and the investigative process. Further supporting compliance is the interview with staff who consistently understood their duty to report while also understanding the need to protect victims' privacy. The Facility Director provided an in-depth memo on how the standards elements are addressed in daily operations.

## **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.*

## **Overall Compliance Determination Narrative**

### **Policies and written/electronic documentation reviewed.**

LightHouse Pre-Audit Questionnaire

Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA)

### **Individuals interviewed/ observations made.**

Vice President for Justice Services

Facility Director

Random Staff

Random Residents

### **Indicator Summary determination.**

Indicator (a). LightHouse has not had a situation where a resident has needed protective services from substantial or imminent risk of sexual assault. The facility has trained its staff to handle these situations consistent with first responder expectations, including taking immediate actions to ensure safety, keeping them apart from any perceived threat, and notification to supervisory staff. Since opening the facility has not had to separate residents as a part of a plan to keep a resident safe from sexual misconduct. The facility takes all inmate conflicts seriously and tries to work with the individuals so they can complete their respective stays. It is clear though no aggression would be tolerated. Residents spoken to did not report any concerns about sexual aggression in the environment. Staff spoken with also were able to describe the steps they would take to protect a resident who had concerns about potential abuse.

### **Compliance Determination**

Since LightHouse has not had to provide protection duties for a resident in danger of sexual assault, the Auditor relied extensively on interviews to determine compliance. Resident who display aggression would be removed from Lighthouse rather quickly so protection duties would be limited as compared to a correctional setting. Interviews with the Vice President for Justice Services and Facility Director confirmed multiple steps that would be enacted to ensure the safety of all clients involved. Those steps would include moving the resident's room, identification of the potential threat, investigation, and the possible transfer of one or the other parties depending on aggression alleged. Random staff who were interviewed stated they would immediately respond to any concern related to residents' safety. The random staff reported they would speak to the at-risk client in a private setting to understand the situation better. After discussing with the resident, they would notify supervisory staff so a solution could be determined while maintaining the resident's safety. Interviews with random residents supported that they could approach staff with a concern related to PREA and felt it would be addressed.

## **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

*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.*

#### Overall Compliance Determination Narrative

##### **Policies and written/electronic documentation reviewed.**

LightHouse Pre-Audit Questionnaire

Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA)

##### **Individuals interviewed/ observations made.**

Facility Director

CRJ PREA Coordinator

##### **Indicator Summary determination.**



**Indicator (a).** Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA) requires that the Director of LightHouse notify the director of another facility if a resident reports previous sexual assault incidents at the other facility. Interview with the LightHouse Director confirms she is aware of this responsibility.

**Indicator (b).** In the interview, the LightHouse Director was aware that notifications must be made within 72 hours of his staff being made aware of a sexual assault at another institution.

**Indicator (c).** The Director of LightHouse reports she would document the notification by making a follow-up email after making initial contact with the Director of the other facility.

**Indicator (d).** The LightHouse Director, and PREA Coordinator confirmed that an investigation would be enacted immediately upon notice from another institution of any criminal behavior at LightHouse.

### **Compliance Determination**

CRJ has not received any reports from other correctional institutions about claims of sexual assaults at LightHouse. The facility did not have to report any claims of sexual assault to any other correctional institution. Compliance, absent a claim that has to be reported to another facility, relied on the LightHouse Director and PREA Coordinator's knowledge, of the standard's requirements, including timeframes for reporting to other institutions. The Auditor also took into consideration CRJ's PREA policy, which addresses the standard language requirements.

## **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.*

#### Overall Compliance Determination Narrative

##### **Policies and written/electronic documentation reviewed.**

LightHouse Pre-Audit Questionnaire  
Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA)  
LightHouse Coordinated Response Plan  
CRJ PREA Training materials  
Agreement with the local hospital to provide SANE services.

##### **Individuals interviewed/ observations made.**

Random Staff  
Case Management Staff  
LightHouse Director  
PREA Coordinator

##### **Indicator Summary determination.**

**Indicator (a).** LightHouse has not had a case requiring a staff member to act as a first responder to a sexual assault complaint. The Auditor had to rely on random staffs' ability to explain their first responder responsibilities. The random staff interviewed described the steps they were trained on, including; separating the victim and the potential threat and securing the crime scene. They also knew to ask both the victim and the accused perpetrator to not shower, wash, brush, eat, drink, or take any other actions that would affect the evidence on them or their clothes. CRJ Policy 900 also sets forth

expectations for staff consistent with this indicator (page 12). The policy states, "Upon learning that a resident was sexually abused, the first staff member to respond to the scene must:

- a. Separate the alleged victim and alleged abuser (to protect the victim and prevent further violence);
- b. Not leave the alleged victim alone;
- c. Ensure no one else enters the area to preserve and protect the crime scene;
- d. Check victim for immediate medical attention and call 911 if warranted.
- e. Contact the Person-in-Charge (Program Director or designee) to request the assistance (including notifying FBOP of incident);
- f. If the abuse occurred within a time period that would still allow for the collection of physical evidence (up to 96 hours), request that the alleged victim not take any action that could destroy physical evidence, including washing or showering, drinking or eating (unless medically indicated), brushing teeth, changing clothes, or toileting."

**Indicator (b).** All staff at LightHouse are trained to be first responders. All staff are trained in the facility's Coordinated Response Plan. The first four steps of the plan described the actions that a person could undertake in a sexual assault as a first responder. The Auditor confirmed with case management staff and the Intake and Release Coordinator that they also are trained as first responders.

### Compliance Determination

As stated above, Auditor had to rely on random staff interviews in determining compliance with the standard. The facility has yet to have a staff person act as a first responder. The Auditor relied on the staff's ability to describe training expectations. The staff were well versed in the expectations of a First Responder, including the protection of the potential victim and the preservation of evidence, be it a physical space or on an individual. Individual staff also noted that the Coordinated response plan could be used as a reference if they were not sure what to do. The plan was visible on tour in several locations. The Auditor also reviewed the PREA training to get an understanding of the information provided to all staff.

## 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

*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.*

#### **Policies and written/electronic documentation reviewed.**

LightHouse Pre-Audit Questionnaire

LightHouse Coordinated Response Plan

Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA)

#### **Individuals interviewed/ observations made.**

Facility Director

Random Staff

#### **Indicator Summary determination.**

Indicator (a). The Facility has a Coordinated response plan available to staff. The plan focuses on the first responder's actions, The Program Director, and the case management staff. Since the agency does not employ medical or Mental Health staff, there are no specific duties for these positions. Local Rape Crisis Agency and the local hospital with SANE nurses are listed in the plan. The plan is also covered in Policy 900.00 Pages 11-13, the policy is descriptive on the roles of line staff, facility and agency administrative response to incidents of sexual misconduct.

#### **Compliance Determination**

The LightHouse coordinated response plan is available to all staff. It is colorful, making it easy to identify, with each step indicating a required action and the individual responsible ensuring it occurs. The staff's awareness of the coordinated response plan supports compliance. The Auditor believes that LightHouse staff are sufficiently trained in implementing the plan if an incident occurs. The LightHouse Director further supported compliance by her knowledge of the plan and the expectation that multiple individuals will have responsibilities. The Auditor made suggestions on improvements to the plan.

### **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.*

#### Overall Compliance Determination Narrative

##### **Policies and written/electronic documentation reviewed.**

LightHouse Pre-Audit Questionnaire

CRJ Employee handbook

Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA)

##### **Individuals interviewed/ observations made.**

Vice President of Social Justice Services

##### **Indicator Summary determination.**

**Indicator (a).** CRJ, the parent organization of LightHouse, does not employ unionized employees. The agency's employee handbook does state that individuals can be placed out of work during an investigation. Page 15-16 of the Agency employee handbook defines the right to discipline employees who engage in "gross misconduct." The document goes on to state the right of CRJ to place employees out on administrative leave during and investigations into their actions. The facility Director confirmed her ability to immediately place a staff person out on leave in an investigation.

**Indicator (b).** The Auditor is not required to audit this provision.

##### **Compliance Determination:**

The Auditor finds the standard to be compliant. The agency has an employment policy that allows LightHouse to put an accused staff person out of work on administrative leave. In doing so, they would be able to protect a resident from any further abuse or subsequent harassment. The employee handbook also supported that there were no collective bargaining contracts and defines that individuals who are subject to an investigation can be placed out of work. The Director confirmed that she would notify the Director of Reentry, the Bureau of Prisons, who would also require the termination of an alleged staff member from having a contact with a potential resident victim.

## **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.*

**Policies and written/electronic documentation reviewed.**

LightHouse Pre-Audit Questionnaire  
Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA)  
CRJ Employee Handbook  
CRJ Retaliation Monitoring form  
Memo on retaliation prohibition

**Individuals interviewed/ observations made.**

Director of LightHouse  
PREA Coordinator  
Vice President of Justice Services.

**Indicator Summary determination.**

**Indicator (a).** Indicator (a). Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA) establishes, on page 4 and 5, an expectation to keep both staff and residents who report or corroborate with an investigation into sexual assault or sexual harassment from any form of retaliation. The policy states The program must employ all available measures to protect vulnerable residents from abuse or prevent abusers from having the opportunity to abuse by: (1) Consultation with the referral source; (2) Removing alleged resident abusers from contact with victims; (3) Removing alleged staff abusers from contact with victims; (4) Monitoring resident rooms, including by direct observation, if necessary; (5) Transferring potential victims/abusers to other facilities, if operationally possible; (6) Actively monitoring, for at least 90 days, the conduct and treatment of residents or staff who reported abuse or harassment, and, of residents who were reported to have suffered abuse to see if there are changes that may suggest possible retaliation by residents or staff; (7) Promptly remedying any signs of retaliation detected; (8) Monitoring any resident disciplinary reports, housing or program changes, or negative performance reviews or reassignments of staff; (9) Continuing monitoring beyond 90 days if the initial monitoring indicates a continuing need; (10) Providing monitoring that includes periodic status checks for residents; and (11) Protecting individuals who cooperate in investigations who express fear of retaliation. b. The program's obligation to protect against retaliation ends if any allegation is unfounded." The Vice President of Justice Services says she would expect the Program Director or Assistant Director to be the facility's primary individuals responsible for monitoring any adverse outcomes after a claim has been made. The facility did not have any sexual abuse cases since opening.

**Indicator (b).** The Director of LightHouse and the Vice President for Justice Services both spoke to the multiple options Community Resources for Justice has to protect residents from retaliation. This includes reassigning rooms or moving residents from one floor to another. In more extreme cases, the agency can explore with the Bureau of Prisons permission to have a client move to another CRJ facility or the individual be removed from the program altogether. CRJ employee handbook and interview with the Vice President confirmed that if an allegation is against a staff person, that individual could be placed on administrative leave while the investigation is happening.

**Indicator (c).** The LightHouse facility has not had a PREA related complaint that would require the monitoring of residents or staff. As noted in indicator (a) the agency policy addresses the requirements of this indicator. The Facility Director was aware that staff and residents who report or cooperate with a PREA investigation should be monitored for a period of 90 days. He was able to describe things that

would be reviewed as a possible symptom of retaliation. Examples include monitoring for discipline, changes in attitude or behaviors, changes in interactions with peers. Though there were no retaliation monitoring for sexual assault claims the facility has adopted a retaliation monitoring form. The Vice President of Social Justice Services would also expect the facility Director to lead the monitoring process. The agency has developed a monitoring tool that would be used to collect information on the areas addressed in this indicator.

**Indicator (d).** The LightHouse Director reports there would be periodic check-ins made by her or the appropriate case management staff to any individual who cooperated in the investigation. The reported contact with clients would be in addition to the regular case management check-ins required for residents. LightHouse vary contacts with clients based on needs but the Director supported the client would be seen at least once a week after a PREA event. By practice, LightHouse case management staff routinely asked residents about their feeling of safety as it relates to sexual misconduct. The Agency adopted a monitoring form in the past year. The retaliation monitoring form has a space for documenting the clients' monitoring process and boxes that coincide with elements to be considered.

**Indicator (e).** As noted in indicator (b), the protections enacted by Community Resources for Justice would extend to any individual who cooperated in the investigation of sexual misconduct.

**Indicator (f).** The Auditor is not required to audit this provision.

### **Compliance Determination**

The Auditor finds that LightHouse is compliant with the expectations of this standard. To date the program has not had to monitor any staff or residents for retaliation. The Director of LightHouse and the Vice President of Social Justice Services are both aware of the conditions they need to monitor for retaliation against any individual who cooperates in an investigation. The Director understood the monitoring should continue even if the perpetrating individual has been removed. Supporting this determination of compliance was the policy statement, the monitoring form in place, the counseling services available to staff and residents, and the interview results. Included in consideration were the residents who consistently supported in interviews they could approach staff and believed they would be kept safe.

## **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.*

**Policies and written/electronic documentation reviewed.**

LightHouse Pre-Audit Questionnaire

LightHouse Pre-Audit Questionnaire

Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA)

**Individuals interviewed/ observations made.**

Facility Director

PREA Coordinator

**Summary determination.**

**Indicator (a).** Policy 900.00 sets forth the requirements of the standard, including an immediate notification by the Program Director to the local police department. Since LightHouse or CRJ staff would not complete a criminal investigation, they will promptly report any allegation of sexual abuse or sexual harassment that appears to be criminal to the Buffalo Police Department. The Director of LightHouse was interviewed as a trained investigator. She reported that the administrative investigation would happen immediately, and it would include a thorough and objective review of the facts. The only delays in the administrative investigations are when those actions would impede the criminal investigation. All interviewed staff understood the need to accept all allegations, including third-party and anonymous reports, and report them immediately.

**Indicator (b).** As noted in 115.234, all CRJ Social Justice facility Directors and Assistant Directors are trained in investigating sexual assault in a criminal justice facility. The training they received was from the National Institute of Corrections. In addition to the LightHouse Director and Assistant Director the other trained individuals who would most likely participate in an investigation are the Agency PREA Coordinator, and the Director of Reentry Operations who supervises the LightHouse leadership. The Director was able to describe the training and the elements that were most helpful.

**Indicator (c).** As stated above, LightHouse would not employ an investigator who would gather DNA or other physical evidence associated with a criminal investigation. DNA and physical evidence collection would be the responsibility of the Buffalo Police and the trained SANEs at the Erie County Medical Center. The CRJ investigator would ensure that the Buffalo Police Department would have access to all electronic monitoring information, or any written reports completed by employees. CJR has trained staff on the importance of preserving the crime scene. During an administrative investigation, interviews would be completed with alleged victims, suspected perpetrators, and any appropriate witness. The investigative staff would also look at the suggested perpetrator's records (residents or staff) to determine if there were prior reports or complaints of sexual misconduct.

**Indicator (d).** This indicator would be the responsibility of the Buffalo Police Department, who would perform a criminal investigation. Since opening LightHouse has not had any sexual misconduct complaints. Interview with the Director was able to describe the steps she would take to ensure open communication in the event of criminal investigations between the Buffalo Police Department and CRJ. The Agency and the police have established a relationship through other non PREA cases.

**Indicator (e).** Interviews with the investigator support that at no time does the Community Resources for Justice require individuals, during an investigation, to undergo a polygraph or other truth-telling device as a condition of said investigation. The investigator confirmed that the credibility of each

individual is determined on an individual basis and not based on the individual's status as a staff member vs. a resident. The Buffalo Police do not require the use of any truth telling devices to initiate a sexual assault investigation.

**Indicator (f).** The Director confirmed that she would decide if staff actions, or failures contributed to the incident occurring as part of the administrative, investigative process and refer them to CRJ Senior Leadership. The Auditor reviewed the steps to be taken in the investigation process by the LightHouse management. The Auditor considered the investigator's knowledge of what should be in an administrative investigation report, the steps taken to ensure a thorough investigation was completed, and the thought process used to draw conclusions. The Director was aware that when a criminal investigation occurs the Administrative Investigation should not impede the criminal investigation process.

**Indicator (g).** Criminal investigations report content would be the responsibility of the Buffalo police department. The Agency would keep any communication on the criminal investigation as well as the administrative investigation. The Director reports they have developed relationships with the Buffalo Police Department since opening to ensure lines of communication can occur during an event like a PREA investigation.

**Indicator (h).** If an allegation is substantiated, the determination of a criminal investigation would be the Buffalo Police Department's responsibility, who would refer to the Erie County Prosecutor for criminal prosecution.

**Indicator (i)** The CRJ PREA Coordinator would retain all investigative reports related to any PREA incident. The agency policy requires retention for a period of 10 years after an individual has left the facility.

**Indicator (j)** The Investigator interviewed confirmed that the departure of an alleged abuser or victim would not result in a premature conclusion of the administrative investigation. Policy 900.00 page 20 confirms that "departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation."

**Indicator (k)** Auditor is not required to audit this provision.

**Indicator (l)** LightHouse has provided documentation of a working relationship with the Buffalo Police Department. The facility Director reported that she would ensure open communication between the two agencies so that federal requirements of PREA, including required notifications, can be completed in a timely fashion. Policy 900.00 (page 20) requires the Director to remain informed about the outside investigative agency's progress.

### **Compliance Determination**

There was no individual who was a reported victim of sexual assault at LightHouse for the Auditor to interview as part of this standards review. Absent a criminal case, the Auditor relied on interviews, policy, training records, and prior experience with CRJ investigative files to determine compliance. The Auditor reviewed the information obtained in the sexual harassment claims. The interviews showed an understanding of the steps necessary to complete a thorough administrative investigation. The information included, the steps necessary to determine the credibility of witnesses, determine how staff actions impacted the incident, collaborate with outside agencies, and records retention requirements. The facility's relationship with the Buffalo Police Department supports there are systems in place to ensure a prompt criminal investigation. As a community confinement facility, it is likely that the

perpetrator of sexual assault or sexual harassment would be removed from the facility, but the investigator understood the necessity of completing an administrative investigation and deciding to substantiate or not substantiate or determine that the claim was unfounded. The interviews support the agency's commitment to ensure safety by training all staff to report every claim no matter the source. The investigator's statement on the investigative process will include determining if staff actions or inactions aided in potential abuse occurring.

## 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.*

#### **Policies and written/electronic documentation reviewed.**

LightHouse Pre-Audit Questionnaire

Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA)

Memo from the Director on standard used to determine outcome.

#### **Individuals interviewed/ observations made.**

Trained staff Investigator

#### **Indicator Summary determination.**



**Indicator (a).** Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA) (page18) stated that no greater standard than a preponderance of evidence would be used in substantiating an administrative investigation. The Interview with an investigator confirmed this expectation.

#### **Compliance Determination**

The Auditor spoke with the Director as the Investigator. CRJ has several staff trained in completing an administrative investigation of PREA claims of sexual abuse or Sexual harassment. The Auditor confirmed there is no greater standard in determining the investigation outcome than a preponderance of the evidence. The Agency Policy also supports a determination of compliance.

### **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 the agency's 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

*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.*

#### Policies and written/electronic documentation reviewed.

LightHouse Pre-Audit Questionnaire  
Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA)  
CRJ Client Notification Form

#### Individuals interviewed/ observations made.

Interview with the LightHouse Director

Interview with Assistant Director  
Interview with PREA Coordinator

### **Indicator Summary determination.**

**Indicator (a).** At the conclusion of an investigation, LightHouse and CRJ administration will ensure, according to interviews, that resident victims are informed of the outcome, including a determination that the claim is substantiated, unsubstantiated, or unfounded. The facility has a form for the notification of the resident on the outcome of sexual assault complaints. The agency form is to be used to inform residents of the outcome of both sexual assault allegations and in allegations of sexual harassment.

**Indicator (b).** As noted in 115.271 (l), if Buffalo Police Department is completing the criminal investigation, the expectation is Facility Director would open up communication channels to ensure sufficient information is obtained in a timely fashion to report to victim residents. CRJ would complete administrative investigations into sexual assault where appropriate. Such investigations would be looking if the staff's actions or inactions played a part in the assault. Absent a case; the Auditor asked the Assistant Director LightHouse about how non-PREA criminal investigation communication occurs between the Buffalo Police Department and CRJ.

**Indicator (c).** Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA) (page 11), states, "following an allegation of abuse by a staff person, "supervising staff shall take steps to separate them, so there is no possibility of further unmonitored contact between them until an investigation is completed. The appropriate staff shall determine if the staff member should be placed on administrative leave pending the results of an investigation". The Assistant Director LightHouse is aware of the required notifications to the victim if an allegation involves a staff person including when the staff person is no longer employed, has been indicted, or when the staff person is convicted.

**Indicator (d).** The Assistant Director LightHouse is also aware of notification to a victim when a resident perpetrator has been indicted or convicted. Since LightHouse's length of stay is usually under six months, notification on convictions would be unlikely and become the responsibility of the Victims' Assistance Office of the New York Attorney General's office. The Assistant Director was also aware of notification to residents when the accused perpetrator is no longer working at that location if they were indicted or if the staff person was convicted.

**Indicator (e).** The facility will provide the resident with a written notification of the investigative outcome. This will also go in the client's permanent record and a copy forwarded to the PREA Coordinator. Documentation can also be written into the SecureManage.

**Indicator (f).** Auditor is not required to audit this provision.

### **Compliance Determination**

The Community Resources for Justice has put in place mechanisms to ensure residents are told of the outcome of sexual assault and sexual harassment claims. In determining compliance, the Auditor reviewed policies, websites, reporting forms and conducted interviews with the Assistant Director who oversees the LightHouse facility staff, the Director who is trained in completing administrative Investigations, and the agency's PREA Coordinator. It was determined based on the above-stated factors that LightHouse is compliant in its ability to report to residents. LightHouse had not had a sexual assault incident, which required resident notification. The agency policy requires notifications to be made on sexual harassment cases. The Auditor relied on the interviews, the reporting forms completed for sexual harassment cases, and the policy in determining compliance.

## 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

*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.*

**Policies and written/electronic documentation reviewed.**

LightHouse Pre-Audit Questionnaire

Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA)

Employee handbook

**Individuals interviewed/ observations made.**

Interview with Director LightHouse

Interview with Human Resources staff.

**Indicator Summary determination.**

**Indicator (a).** CRJ Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA) states staff can be subjected to “disciplinary sanctions up to and including termination for violating CRJ sexual abuse or sexual harassment policy.” (900.00) CRJ employee handbook (page 15) further informs staff of potential discipline. Employees may also be disciplined or terminated for gross misconduct. No employees of LightHouse have been disciplined for sexual harassment or sexual abuse of clients at LightHouse.

**Indicator (b).** CRJ Policy 900.00 states, “Sexual abuse, sexual harassment or sexual contact with residents shall subject staff to appropriate discipline, up to and including termination.” The Employee handbook states, “Gross misconduct, including, but not limited to violations listed below, may result in the employee being terminated for a single violation.” Gross Misconduct includes acts which are criminal or presents a threat to the agency, its residents, or staff. Human Resources staff and the Director LightHouse confirmed that employees who engage in sexual misconduct with a resident can be terminated for the first offense.

**Indicator (c).** Community Resource for Justice is an at-will employer and has the ability to determine appropriate sanctions for non-criminal behavior. Policy 900.00 utilizes the standard language to state consequences should be commensurate with the nature of the offense and the employee’s history with the agency. CRJ Employee handbook notifies staff that they can be terminated “All CRJ employees are at-will, which means they may be terminated at any time and for any reason, with or without advance notice. Employees are also free to quit at any time.” Interviews confirmed that discipline for non-criminal behaviors would be based on the employee’s overall history and the nature of the offense.

**Indicator (d).** LightHouse does not employ any individuals who perform duties in a licensed capacity. The facility will notify the Buffalo Police Department of all sexual assaults or sexual harassment behavior that appears to be criminal in nature, even if the employee has left the agency. The Director LightHouse confirmed that outcomes of administrative or criminal investigations related to sexual abuse or sexual harassment of clients would be forwarded to Human resources to become part of their employment record.

**Compliance Determination**

The Community Resources for Justice has a policy in place that states staff who violate agency sexual abuse or sexual harassment policies are subject to disciplinary action (900.00 pages 20). Disciplinary actions, up to and including termination, will be taken for a substantiated finding of sexual abuse. Discipline, per policy, will be proportional to the nature and circumstances of the acts committed and comparable to other staff with similar histories. CRJ requires all allegations of sexual abuse reported to the local authorities regardless of whether the staff resigns or is terminated.

No LightHouse staff has been disciplined for a PREA related violation in the past year because of a criminal or administrative investigation. Absent a recent staff discipline incident: compliance was based on policy and the interview with the Director LightHouse, the agency PREA Coordinator, and the Human Resources staff. The agency reports it has previously disciplined staff related to PREA concerns at their other facilities in the past. The Auditor also took into consideration the CRJ employee handbook, which described the discipline process for staff, including grounds for immediate termination for “gross misconduct.”

## 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.*



**Policies and written/electronic documentation reviewed.**

LightHouse Pre-Audit Questionnaire

Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA)

**Individuals interviewed/ observations made.**

LightHouse Director

PREA Coordinator

**Indicator Summary determination.**

**Indicator (a).** LightHouse does not employ any individual contractor to provide direct service to residents in the licensed capacity. The facility has no direct service contractors; all contractors entering the facility are supervised by staff. The contractors entering are one-time individuals with the exception of food service company whose staff have undergone criminal background checks and are provided basic information on PREA. The food service staff drop off meals while on-site two times per day and are supervised at all times by staff. Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA) allows for the immediate cessation of visits by any contractor or volunteer accused of engaging in sexual misconduct. "Any contractor or volunteer who engages in sexual abuse or sexual harassment shall be prohibited from entry to any CRJ programs and shall be reported to law enforcement agencies, (unless the activity was clearly not criminal), and to relevant licensing bodies." The agency policy requires all criminal behavior to be reported to the police no matter if the individual is an employee, a contractor, a volunteer, or a visitor. During COVID -19, outside access to LightHouse has been reduced for the safety of all. Client services are available in the community, including the Crisis Services who can provide support or therapy to individuals with past histories of sexual abuse.

**Indicator (b).** According to CRJ and LightHouse policy 900.00 (pages 20-21), in the case of any violation of boundary issues by any contractor or volunteer, the Facility Director will determine if the violation is non-criminal actions should result in the termination of their contact with residents. "The facility shall take appropriate remedial measures and shall consider whether to prohibit further contact with residents, in the case of any other violation of CRJ sexual abuse or sexual harassment policies by a contractor or volunteer." According to the LightHouse Director, criminal actions would notify the Police and funding source. She confirms the individual would have an immediate termination of access to residents during the investigation.

**Compliance Determination**

LightHouse does not employ contractors who provide direct services to the clients at the facility. LightHouse does not currently have any volunteers and only one college intern. LightHouse policy 900.00 Resident and Staff Sexual abuse and Sexual Misconduct (PREA) (page 18) require the notification to law enforcement of any PREA violations, and the misconduct would be grounds for barring admission to the facility (page 20). As noted in 115.232, all individuals entering the facility are educated about PREA, and Contractors or volunteers are supervised. The facility has not employed or received any voluntary services of a professional to whom a licensing board would be informed for violations of PREA. The Agency PREA Coordinator reports that no volunteer or contractor was the subject of any PREA related investigation in the past year or required any corrective actions. Compliance, absent any discipline of volunteers or contractors, is based on policy, documentation of education materials available to educate volunteers, and interviews with the LightHouse Director and the agency PREA Coordinator.

## 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)

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

## Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

#### **Policies and written/electronic documentation reviewed.**

LightHouse Pre-Audit Questionnaire  
 Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA)  
 Resident Handbook (conduct)  
 FBOP Prohibited acts  
 FBOP Disciplinary Hearing form

#### **Individuals interviewed/ observations made.**

Program Director  
 Representative of Referring Agency  
 Residents

#### **Indicator Summary determination.**

**Indicator (a).** Policy 900 Staff and Resident Sexual Abuse (PREA) sets forth the requirement of any resident found to have engaged in resident-on-resident sexual abuse can be subject to discipline. It states, "residents will be subject to disciplinary sanctions pursuant to a formal disciplinary proceeding following an administrative finding that the resident engaged in resident-on-resident sexual abuse or sexual harassment or following a criminal investigation" (page 21). At LightHouse, there have been zero resident-on-resident sexual abuse cases. Without a case of resident-on-resident abuse, the Auditor must rely on the policy, resident handbook information defining discipline and facility leadership. As a Community Confinement Center, the belief is that a new criminal charge would likely result in an immediate placement in a higher level of custody.

**Indicator (b).** The Facility Director reports that the discipline process is fair and has consequences that vary based on the severity of guideline violation. The resident handbook page-19 outlines prohibited actions and types of sanctions for non-criminal acts. As a community confinement center, residents engaging in sexual abuse would be removed immediately by the referring authority. An interview with the facility Director confirms that the individual's prior disciplinary history could weigh in the process and that sanctions would be consistent with those who committed similar offenses.

**Indicator (c).** Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA), page 21, requires consideration of the resident's mental illness or disability in determining appropriate

sanctions. Policy states, "The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed." An interview with the facility Director confirms that any discipline of the resident takes into consideration the resident's ability to comprehend their actions.

**Indicator (d).** As a community confinement facility, it would be unlikely the perpetrator individual of sexual abuse would stay in the facility. Individuals who engage in such actions would likely be returned to higher levels of custody. LightHouse can refer individuals with sexual abuse histories to outside counseling at Buffalo's Crisis Services or other mental health programs in the area including those funded by the Federal Bureau of Prisons. The Crisis Services staff confirms they can provide this counseling to individuals with sexual abuse histories.

**Indicator (e).** Policy 900.00 confirms on page 21 that residents will not be disciplined for engaging in consensual sexual contact with the staff. "The program may discipline a resident for engaging in sexual contact with a staff only after an investigation finding the staff did not consent." The Auditor also confirmed with the Program Director that residents in these situations would be considered victims and not be subjected to disciplinary actions.

**Indicator (f).** Community Resources for Justice Policy 900.00 and the LightHouse resident handbook (page 6) confirm that a resident can be disciplined if they purposefully lied in submitting a PREA related complaint. The policy states that complaint files with a reasonable belief that the alleged conduct occurred shall not constitute a false allegation. CRJ administration confirmed that this would only occur after the completion of an investigation, which supported such intent in its findings. Interviews with residents confirmed an understanding that PREA complaints cannot result in discipline without an investigation substantiating an intentionally false report. There were zero investigations of false reports related to sexual abuse or sexual harassment claims in the past year.

**Indicator (g).** LightHouse prohibits sexual contact between residents. It is stated in the resident handbook on page 16 that "Residents may not engage in romantic relationships at LightHouse." According to the facility Director, if residents have engaged in sexual activities, there would be an investigation of facts, and residents would be met with to ensure there was no intimidation by either party to claim the activity as consensual. Residents who would be disciplined through this process would have notifications sent to their referring authorities.

#### **Compliance Determination:**

LightHouse has a policy that addresses the concerns of this standard. The residents are also afforded information related to sexual misconduct in the facility in the resident handbook. These documents describe addressing the conditions in which a resident could be disciplined, that sanctions be equivalent to the nature of the misconduct, the required consideration of a resident's mental health or functioning level, and the consequences for sexual misconduct between residents. Interviews with the Program Director confirmed policy expectations, including no discipline for the residents in consensual acts with staff persons. There have been no disciplines in the 18-months the program has been open for sexual abuse or sexual harassment. In the investigation into sexual harassment, the client who filed the complaint admitted they did not want the individual punished; they wanted the behaviors to cease.

Discussions with the referring agencies confirmed residents who sexually assault others would be removed to a higher level of custody. The referring agency would determine any discipline of a perpetrator, and the referral to mental health services would occur at the next facility. Interviews with residents confirm that they are told of prohibited acts at LightHouse at admission and are provided a

handbook that outlines the discipline process. Compliance, absent a disciplinary event, is based on policy, information available through the client handbook and administration, line staff, and resident interviews. Further supporting compliance is the availability for treatment of individuals with an offending history.

## 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

*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.*

#### **Policies and written/electronic documentation reviewed.**

LightHouse Pre-Audit Questionnaire  
Policy 900 Staff and Resident Sexual Misconduct (PREA)  
NY Dept of Public Health Website

#### **Individuals interviewed/ observations made.**

Erie County Medical Center  
Buffalo Medical Center  
NY Department of Public Health  
Random Staff  
Program Director

#### **Indicator Summary determination.**

**Indicator (a).** LightHouse has in place emergency medical treatment for victims of sexual abuse. The facility has entered into a relationship with Erie County Medical Center who can provide emergency services, including access to trained Sexual Assault Nurse Examiners. The facility coordinated response plan requires potential victims to be sent to the hospital. Also, the local rape crisis agency Crisis Services (CS) would also aid the victim at a hospital. Ongoing support for medical support for victims of abuse can occur at Erie County Medical Center. Policy 900.00 Staff and Resident Sexual Misconduct (Page 14) has language requiring unimpeded access to care for victims of sexual abuse consistent with the language of the indicator. "Resident victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment."

**Indicator (b).** LightHouse does not employ medical or mental health staff. All victims would be sent to the hospital. All staff at LightHouse are trained as first responders. In their interviews, random staff were aware of the need to preserve evidence and the importance of supporting the victim emotionally. LightHouse has a coordinated response plan that confirms this practice. Interviews with staff further confirmed the importance of an immediate response to both actual sexual abuse incidents and in any situation where residents state concern of potential abuse. Staff described the importance of providing physical and emotional safety to the victim and the importance of immediate access to hospital care.



**Indicator (c).** Interviews with Erie County Medical Center representatives supported residents would be offered information on emergency contraception and prophylactic medication. After the emergency visit to the hospital, they may do follow-up care or at area health clinics, including Erie County Medical Center's clinic where they can receive appropriate services, including medication, even if initially refused.

**Indicator (d).** Community Resources for Justice policy 900.00 (page 14). States "treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation." Interview with community service providers and information on the New York Dept of Public Health website both confirm there is no cost for the treatment of victims of sexual assault. The New York Office of Victim Services (OVS) provides the funds to hospitals. The statement includes, "The Office of Victim Services directly reimburses medical providers for forensic rape examinations (FREs) if victims of sexual assault do not have access to private health insurance or chose not to use their private health care insurance for the examination. This measure is an exception to the agency's payer of last resort rule and provides for the personal privacy of victims. ."

### **Compliance Determination**

LightHouse does not employ medical or mental health staff. As a result, they have trained all staff in the duties of the first responders, including the importance of getting the victim to treatment services as soon as possible. Line staff are aware they should only ask the victim enough information to be able to obtain appropriate treatment. They are also mindful of the importance of protecting evidence, including informing resident victims not to take any action that would degrade evidence. Victims of sexual assault at LightHouse have appropriate access to medical and mental health services without cost. The Auditor finds the standard to be in compliance. Absent a case requiring the plan's implementation, the Auditor relied on policy, staff, and administration knowledge of the coordinated plan and information from community resources in determining compliance.

## **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. *Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☒ 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. *Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☒ 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

*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.*

**Policies and written/electronic documentation reviewed.**

LightHouse Pre-Audit Questionnaire  
Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA)  
LightHouse Resident Handbook.  
Case management notes  
PREA Screening results

**Individuals interviewed/ observations made.**

Residents with prior victimization histories  
Case management staff  
Local rape crisis agency  
Local medical and mental health clinics

**Indicator Summary determination.**

**Indicator (a).** LightHouse will offer medical or mental health evaluations and treatment as needed to individuals sexually abused either at the facility or during a previous institutional stay. A resident who reports prior victimization history to the LightHouse staff would be offered a referral to community-based counseling services available in the region. Federal Bureau of Prisons (FBOP) contracts locally that provides client access to services including mental health, substance abuse and psychiatric care. Residents acknowledged they believe the staff will aid individual victims in finding services. The Auditor received information to support that individuals with past victimization histories were offered a referral for counseling services. Identified residents with victimization histories interviewed confirmed the access to community-based counseling services. Representative of the Erie County Medical center confirmed their ongoing support to victims.

**Indicator (b).** Representatives of local medical and mental health clinics confirm they can provide ongoing services while the individual remains at LightHouse. LightHouse does not subcontract for these services, but they are available to the resident through various local service providers. If the resident leaves the area, these agencies confirm they will aid in the continuity of services by making referral recommendations close to the community where they will be living. The representative of CS also confirmed that individuals with whom they have provided supportive services would be offered information about the availability of support in the community in which the individual was going to live.

**Indicator (c).** Medical and mental health services are provided at several community-based providers. Representatives told the Auditor of these facilities that LightHouse clients receive the same services that all individuals living in the community seeking services would receive. In addition to the interview with community agency representatives, the Auditor reviewed several agencies' websites for information on service availability.

**Indicator (d).** The Erie County Medical Center staff confirmed residents of LightHouse who were victims of sexual assault would be offered pregnancy testing.

**Indicator (e).** The Erie County Medical Center staff confirmed if the sexual assault results in pregnancy, the victim would receive counseling on pregnancy-related medical services.

**Indicator (f).** The Erie County Medical Center staff confirmed HIV testing is provided to all victims of sexual abuse.

**Indicator (g).** Treatment services are provided to victims even if they do not name the abuser or cooperate fully with the investigation. Interviews confirmed the stated CRJ policy (900.00 (page 14), "treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation."

**Indicator (h).** The CRJ policy 900.00 (page 14) puts in place a follow-up assessment requirement if a perpetrating individual were to remain in custody. "The program will 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. "Community agencies confirm an evaluation of a sexual offender can be provided if required. As a Community Confinement Facility, it would be unlikely a perpetrating individual would remain in such a level of custody. Such individuals would most likely be transferred back to higher custody FBOP facilities or local police custody as part of the ongoing criminal case.

#### **Compliance Determination**

The Community Resources for Justice is committed to ensuring residents in all their programs have ongoing access to services if they have been a victim of sexual abuse in any criminal justice setting. Agency Policy 900.00 speaks to each aspect of this standard. The agency has also entered into relationships with area service providers who can provide victims of abuse the appropriate ongoing support and treatment. Interview with community health providers confirmed that resident victims could receive free of charge services, including HIV testing and prophylactic treatment and pregnancy testing and related services. The Auditor, in determining compliance, considered conversations with the community service providers, interviews with case management staff and residents with victimization histories, as well as resident records. The Auditor also completed internet research on the various health service agencies to further support the finding of compliance.

## **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

*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.*

### **Policies and written/electronic documentation reviewed.**

LightHouse Pre-Audit Questionnaire

Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA)

PREA Incident review form

### **Individuals interviewed/ observations made.**

LightHouse Director

Vice President of Justice Services

Director of Reentry Operations

PREA Coordinator

### **Indicator Summary determination.**

**Indicator (a).** Policy 900.00 Staff and Resident Sexual Misconduct (page 21) set forth the obligation to have a critical review of all incidents of sexual abuse unless the allegation has been unfounded. "The facility shall conduct a sexual abuse or sexual harassment incident review at the conclusion of every sexual abuse/harassment investigation, including where the allegation has not been substantiated" The agency policy goes beyond the standard requirement as it requires reviews of sexual harassment cases in addition to the sexual abuse cases. There have been no claims of sexual abuse at LightHouse in the past three years.

**Indicator (b).** Policy 900.00 states the review will normally occur within 30 days of the conclusion of an investigation. Without a complaint, the Auditor can only assess the timeliness based on policy language and interviews with senior management staff.

**Indicator (c).** The review team would include the agency and facility management, including the PREA Coordinator, Case Managers, and include the input of information obtained from law enforcement or community medical or mental health service providers. The Facility Director also reported the Agency PREA Coordinator would be invited to the review. The Director of Reentry Operation will also complete a critical review of the incident.

**Indicator (d).** The CRJ policy 900.00 (pages 21-22) defines the elements to be considered by the review team consistent with this indicator's requirement. The Policy states, "The review team shall:

- Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse;
- Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility;
- Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;
- Assess the adequacy of staffing levels in that area during different shifts;

e. Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff and current camera systems; and  
f. Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to sections a. – e. (above) and any recommendations for improvement, and submit such report to CRJ's Chief Operating Officer (COO), the Program Director and the PREA Coordinator.  
5. The facility shall implement the recommendations for improvement or shall document its reasons for non-compliance. In addition to the policy, the Auditor was able to see the intended form used to record the information discussed. The Auditor also confirmed with the Facility Director and the PREA Coordinator the elements that would be discussed."

**Indicator (e).** Absent a PREA complaint of sexual assault or sexual harassment; the Auditor relied on the language in Policy 900.00 and interview with facility and agency administration to understand how information from incident reviews would spur action.

### **Compliance Determination**

LightHouse has not had an incident of sexual assault or sexual harassment since opening. As a result, the Auditor had to rely on policy and interviews to confirm compliance. Interviews with senior management of the agency and facility support an understanding of the requirements of the indicators. The Interviews also supported an understanding of how critical review could put into action changes in policy or procedures if needed.

## **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.*

#### Policies and written/electronic documentation reviewed.

LightHouse Pre-Audit Questionnaire  
Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA)  
PREA Annual report  
PREA Data Spreadsheet

#### Individuals interviewed/ observations made.

PREA Coordinator

#### Indicator Summary determination.

**Indicator (a).** CRJ collects uniform data on all its facilities. The Auditor was provided with a spreadsheet of Data, which includes some 56 data points related to PREA. The spreadsheet collects information on PREA complaints/investigation and tracks screening information, population, grievances, searches, and number of notifications of investigation outcomes, to name a few items. The definitions used by the agency in Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA) are consistent with the PREA guidelines for Sexual Abuse and Sexual Harassment

**Indicator (b).** The agency takes collected aggregate data at the facility level and the agency level to attempt to identify trends. CRJ management interviews support an active review of all incidents to determine trends or needs. A client safety issue identified in non-PREA incidents could result in a



solution that could also benefit sexual safety (i.e., Camera purchases). The facility has completed an annual report which shows aggregate data.

**Indicator (c).** The Auditor compared interviews with the Agency PREA Coordinator and information from the PREA DATA Spreadsheet to the SSV-4 form. The Auditor was able to identify the key elements of the Survey of Sexual Violence in the CRJ data report. Each of the agency's reentry facilities are required to forward to the Quality Assurance Department. The PREA Coordinator is the Deputy Director of Standards and Quality Assurance.

**Indicator (d).** All incident reports and investigations are forwarded to the agency PREA Coordinator for the required storage.

**Indicator (e).** N/A- the facility does not contract for the confinement of residents.

**Indicator (f).** N/A- The Department of Justice has not asked LightHouse for the SSV data, though the elements collected by the facility and the PREA Coordinator to support an ability to complete said report.

### **Compliance Determination**

The Community Resources for Justice collects information sufficient to complete the Survey of Sexual Victimization (SSV) in all its programs, including LightHouse. Indicator (e) does not apply as CRJ does not contract for beds. LightHouse has not been requested to complete the SSV report or provide other related data to the Department of Justice (indicator (f)). The Auditor was also able to see a summary report of all programs CRJ runs and their incidents of PREA related events. The report ensures uniformity of data and incident-based tracking of sexual assaults and sexual harassment complaints. The agency policy 900.00 (page 22) commits the agency to comply with the standard's data collection requirement. Compliance is based on the information provided to the Auditor and the interview with the Agency PREA Coordinator, who oversees Quality Assurance in the Reentry facilities. The agency PREA Coordinator is responsible for maintaining the agency aggregate data on all facilities.

## **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

*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.*

#### Policies and written/electronic documentation reviewed.

LightHouse Pre-Audit Questionnaire

Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA)

#### Individuals interviewed/ observations made.

PREA Coordinator

Vice President of Social Justice Services

Facility Director

#### Indicator Summary determination.

**Indicator (a).** CRJ's PREA Coordinator reportedly meets with the Social Justice Services leadership monthly. The group reviews any PREA related concerns or other client safety issues and looking for trends. If a sexual abuse incident review identified a concern, this group would further assess the nature of the corresponding response at the agency level. Since this group member would also be involved in the facility level reviews, they would enable change, when needed, across all facilities. These steps provide the basis for the annual report analysis.

**Indicator (b).** The Auditor's review of the annual report shows a comparison with the previous year's data.

**Indicator (c).** The Annual Report is on the agency website. The last five years reports are currently available.

**Indicator (d).** The agency has not had to redact information to date that would impact the security of the facility.

### **Compliance Determination**

LightHouse and the Community Resources for Justice policy (900.00) addresses the standard's requirements on the use of data for corrective action. CRJ's Standards and Quality Assurance Department have developed a database that supports corrective action through routine monitoring of elements. The department collects over 50 factors related to PREA and has the mechanism to assess agency-wide needs/improvements. The features look at various indicators in the facility's efforts to prevent, detect, and respond to PREA incidents, including education, screening, and investigatory requirements. Since the facility does not have a history of PREA incidents, there is limited data from which to make a critical analysis. As a result, the agency looks at these events, along with other non-PREA events, when determining safety concerns. The PREA Coordinator leading the agency's standards and accreditation process has created a system in which problem areas can be identified and corrective action plans monitored. The agency PREA Coordinator, the Facility Director, and the Vice President of Social Justice Services all committed in interviews to using data to inform practice and identify change when needed. The Agency has posted to the website an annual report approved by the agency's Chief Executive Officer. The report looks at the data across the system and points toward the agency's ongoing efforts to be responsive. Compliance is based on the data provided, the information posted to the agency website and the interviews. The interviews supported a consistent message; that data analysis for program improvement is an agency-wide practice.

## **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.*

### Overall Compliance Determination Narrative

#### **Policies and written/electronic documentation reviewed.**

LightHouse Pre-Audit Questionnaire  
 Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA)  
 Policy 1.1.4 Case Record  
 CRJ website  
 Annual PREA reports

#### **Individuals interviewed/ observations made.**

PREA Coordinator  
 Facility Director  
 Tour of LightHouse

#### **Indicator Summary determination.**

**Indicator (a).** Agency records are maintained securely in the SecurManage software program. The system reportedly utilizes access controls to different fields of information based on an employee job description. The facility has a Policy 1.1.4 Case Records that defines the confidentiality of the records.

**Indicator (b).** CRJ Website has the last four years of annual reports available to the public.

**Indicator (c)** The Auditor's review of aggregate reports shows no identifiers are used that could result in the identification of any victim of sexual abuse.

**Indicator (d).** The PREA Coordinator reports PREA data will be maintained for at least ten years.

### **Compliance Determination**

The Community Resources for Justice PREA policy 900.00 addresses this standard's requirements on pages 21- 22. All facility data is provided to the agency PREA Coordinator responsible for maintaining and securing all data. In the event of an incident, all identifying information would be removed before any information is made public. CRJ has a unit dedicated to Standards and Quality Assurance; it is this unit's responsibility to maintain data for a minimum of 10 years. No state or local law is requiring more extended maintenance of the records. The PREA Coordinator works with the Agency's Head and the Vice President of Justice Services to develop an annual report.

Compliance is based on the annual report's information, which includes no identifiers and includes information on all PREA required facilities run by CRJ. The policy indications on handling information support compliance, as did interviews with the agency's PREA Coordinator and facility Director. The interviews support an understanding that all data is maintained for at least ten years. The annual report is posted on the agency website as required.

## **AUDITING AND CORRECTIVE ACTION**

### **Standard 115.401: Frequency and scope of audits**

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

#### **115.401 (a)**

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

#### **115.401 (b)**

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

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

#### 115.401 (h)

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

#### 115.401 (i)

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

#### 115.401 (m)

- Was the auditor permitted to conduct private interviews with residents? ☒ 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.*

### Overall Compliance Determination Narrative

#### Policies and written/electronic documentation reviewed.

LightHouse Pre-Audit Questionnaire  
CRJ Website/ PREA

**Individuals interviewed/ observations made.**

TOUR of LightHouse

General observation of staff and resident interactions by the Auditor

**Indicator Summary determination.**

**Indicator (a).** CRJ is in its third cycle of audits. In the last three years, the agency had six adult Reentry programs, all of which were audited on compliance with PREA. The LightHouse and McGrath programs were added this PREA cycle. Both were in the first 18 months of operation.

**Indicator (b).** CRJ has Audits spread out over all three years of the Audit cycle. The agency has added and lost programming but has still maintained audits in each of the cycle years. This is LightHouse's first PREA Audit. The Agency will have completed more than 1/3 of their facilities in this audit year.

**Indicator (h).** The Auditor was not only provided access to all areas during the tour and was also able to move freely about the facility to observe staff and resident interactions. The Auditor, staff, and residents practiced social distancing, with interviews occurring with more than 6 feet of space between the auditor and the person being interviewed. Both the Auditor and the individuals being interviewed wore masks. The interviews occurred in a private office space on the first floor of the facility.

**Indicator (i).** The Auditor was permitted to request and receive copies of relevant documents. Information was provided in advance, and more was furnished at the auditor's request when on-site. The Agency PREA Coordinator provided additional clarity as needed during the post audit period.

**Indicator (m).** The Auditor was able to meet in a private space with clients and staff. The second-floor conference room/ computer lab was the space most used by the auditor on days one and two.

**Indicator (n).** Posting with the Auditor's contact information was found throughout the facility. The Auditor confirmed the postings were up for weeks prior to the site visit.

**Compliance Determination**

The standard is Compliant based on evidence that the organization Community Resources for Justice has maintained a consistent application of PREA, including required audits over the last five years. As an Auditor, the facility was helpful in preparing documents and the support of staff to get the identified individuals to the interviews in a timely manner.

**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. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. 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.*

#### Overall Compliance Determination Narrative

##### **Policies and written/electronic documentation reviewed.**

LightHouse Pre-Audit Questionnaire  
Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA)  
CRJ website  
Annual PREA reports

##### **Individuals interviewed/ observations made.**

PREA Coordinator  
Facility Director

##### **Summary determination**

**Indicator (f).** The Community Resources for Justice has posted on its agency's website (CRJ.org) PREA Audit reports Dating back to 2015. The PREA Audits cover all the facilities in Social Justice Programs required to meet PREA.

##### **Compliance determination**

The Community Resources for Justice is compliant based on the agency website's review, which showed prior PREA reports posted.

## 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.<sup>1</sup> Auditors are not permitted to submit audit reports that have been scanned.<sup>2</sup> See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Jack Fitzgerald

7-5-21

**Auditor Signature**

**Date**

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

<sup>2</sup> See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.