The Prison Rape Elimination Act of 2003 (PREA; Public Law 108-79), was enacted to address sexual abuse problems in incarcerated offender populations. In addition to setting mandatory standards for the detection, prevention, and punishment of sexual abuse or rape in prisons, PREA requires all correctional facilities to collect and report detailed information regarding sexual victimization of inmates.

On August 20, 2012 (updated January 6, 2014), the Bureau of Prisons (BOP) published internal policy implementing the PREA regulations promulgated by the Attorney General. The policy emphasizes the zero tolerance for sexual abuse or harassment of any type by staff or inmates in the BOP. The BOP's National and Regional PREA Coordinators and institution PREA compliance managers continue to oversee agency implementation of the law and regulations and BOP policy. The agency also continues to provide training for all staff on PREA generally.

Standards 115.87 and 115.88, which are detailed below, delineate specific data monitoring and collection requirements. This document summarizes the information which will be provided to the Bureau of Justice Statistics (BJS) by the BOP in accordance with PREA.

I. Scope of Assessment: This report provides a review of the incident-based and aggregate data collected for calendar year (CY) 2013. Factors such as motivation and other possible contributing factors are reported when available. This report includes comparisons to data from the CY2012 report; however, comparisons to the previous year's data must be done with caution, as data was not required to be collected for one full year in CY2012.

II. Inmate-on-Inmate Abuse Data Collected: The BOP includes **121** prisons and satellite camps. During CY2013, there were **119** prisons. In some cases, multiple facilities are co-located, comprising a correctional complex. In addition, the agency utilizes **14** Large Secure Contract (LSC) facilities, all of which are low security. During the CY2013 data collection period, **68** BOP facilities and **7** LSC contract facilities had at least one sexual abuse allegation. There were a total of **182** allegations at BOP facilities and **12** at LSC facilities. There are **28** allegations at BOP facilities pending further review / investigation. The following table presents the allegation details.

§ 115.87 DATA COLLECTION

(a) The agency shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions.

(b) The agency shall aggregate the incident-based sexual abuse data at least annually.

(c) The incident-based data collected shall 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.

(d) The agency shall maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

(e) The agency also shall obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its inmates.

(f) Upon request, the agency shall provide all such data from the previous calendar year to the Department of Justice no later than June 30.

§ 115.88 DATA REVIEW FOR CORRECTIVE ACTION

(a) The agency shall review data collected and aggregated pursuant to § 115.87 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by:

(1) Identifying problem areas;

(2) Taking corrective action on an ongoing basis; and

(3) Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole.

(b) Such report shall include a comparison of the current year's data and corrective actions with those from prior years and shall provide an assessment of the agency's progress in addressing sexual abuse.

(c) The agency's report shall be approved by the agency head and made readily available to the public through its Web site or, if it does not have one, through other means.

(d) The agency may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility, but must indicate the nature of the material redacted.

Inmate-on-Inmate Assault Data		
Minimum Facility	Allegations	Substantiated
N/A	0	0
Minimum Total	**0**	**0**
Low Security Level Facilities	**Allegations**	**Substantiated**
FCI Big Spring	3	1
FCI Beaumont	1	
FCI Danbury (F)	3	
FCI Dublin (F)	3	
FCI Fort Dix	2	1
FCI Forrest City	1	
FCI Fort Worth	2	
FCI Miami	1	
FCI Milan	5	
FCI Oakdale	1	
FCI Petersburg	1	
FCI Sandstone	1	1
FCI Tallahassee	1	
FCI Waseca (F)	6	
FCI Yazoo City	1	
Low Total	**32**	**3**
Medium Security Level Facilities	Allegations	Substantiated
FCI Allenwood	1	
FCI Beaumont	1	
FCI Beckley	3	
FCI Butner I	2	
FCI Butner II	2	
FCI Coleman	1	
FCI El Reno	1	
FCI Estill	2	
FCI Fairton	2	
FCI Forrest City	1	
FCI Jesup	3	
USP Lompoc	5	
USP Marion	1	
FCI McDowell	1	
FCI Memphis	3	
FCI Mendota	1	
FCI Marianna	3	
FCI Otisville	2	1
FCI Pekin	1	1
FCI Petersburg	5	
FCI Phoenix	1	
FCI Schuylkill	1	
FCI Talladega	3	
FCI Terre Haute	4	
FCI Victorville I	1	
FCI Victorville II	2	
FCI Williamsburg	1	
Medium Total	**54**	**2**
High Security Level Facilities	Allegations	Substantiated
USP Allenwood	5	
USP Atwater	3	
USP Canaan	4	
USP Coleman II	8	
USP Coleman I	4	
USP Florence	1	
USP Lewisburg	3	
USP McCreary	3	
USP Pollock	2	
USP Tucson	12	1
USP Terre Haute	1	
USP Victorville	4	
High Total	**50**	**1**
Administrative Security Level Facilities	Allegations	Substantiated
MDC Brooklyn	1	
FMC Butner	2	
FMC Carswell (F)	8	1
MCC Chicago	2	
FDC Houston	1	
MDC Guaynabo	1	
FMC Lexington(F)	1	
MDC Los Angeles	5	
FTC Oklahoma City	5	

FDC Philadelphia	3	
FMC Rochester	4	
MCC San Diego	8	
FDC Seatac	3	1
MCFP Springfield	2	
Administrative Total	**46**	**2**
LSC Facilities	Allegations	Substantiated
Eden	2	
D. Ray James	2	
McRae	1	
Moshannon Valley	2	
Northeast Ohio	2	
Rivers	2	
Taft	1	1
LSC Total	**12**	**1**
	Grand Totals	
Bureau of Prisons Facilities: Total Number of Allegations	182	8
LSC Facilities: Total Number of Allegations	12	1

Key/Notes:

- (F) =Female Institution
- Minimum security level facilities are stand-alone camps; if an institution has a satellite camp or federal satellite low, the reporting numbers are combined.

III. Inmate-on-Inmate Incident-Based Assessment for Substantiated Cases: There were nine substantiated cases of inmate-on-inmate sexual abuse during this reporting period. Specific information regarding these incidents is provided below:

FCI Big Spring:

1. Type of Incident: Sexual Act
2. Location: Housing Unit Restroom
3. Details: The Hispanic male inmate/victim reported to staff that he performed oral sex on a white male inmate. It was determined, due to his mental illness the inmate was incapable of giving consent to engage in any non-coercive sexual behavior.
4. The incident occurred between inmates of differing backgrounds.

FMC Carswell:

1. Type of Incident: Sexual Contact
2. Location: Housing Unit Shower Area
3. Details: The Asian female inmate/victim reported to staff that a Hispanic female inmate touched her in a sexual manner.
4. The incident occurred between inmates of differing backgrounds.

FCI Ft. Dix:

1. Type of Incident: Sexual Act
2. Location: Housing Unit Cell
3. Details: Two white male inmates/victims reported to staff that an African American male inmate sexually assaulted them in their housing unit.
4. The incidents occurred between inmates of differing backgrounds.

FCI Otisville:

1. Type of Incident: Sexual Contact
2. Location: Dining Hall
3. Details: The Hispanic male inmate/victim reported to staff that an African American male inmate touched him sexually on the buttock.
4. The incident occurred between inmates of differing backgrounds.

FCI Pekin:

1. Type of Incident: Sexual Contact
2. Location: Recreation
3. Details: The white male inmate/victim reported to staff that a Native American male inmate touched him sexually on the buttock.
4. The incident occurred between inmates of differing backgrounds.

FCI Sandstone:

1. Type of Incident: Sexual Contact
2. Location: Housing Unit Cell
3. Details: The Hispanic male inmate/victim reported to staff that a white male inmate touched him sexually in his groin area.
4. The incident occurred between inmates of differing backgrounds.

FDC Seatac:

1. Type of Incident: Sexual Contact
2. Location: Special Housing Unit Cell
3. Details: The white male inmate/victim reported to staff that another white male inmate touched him sexually while he was showering.
4. The incident occurred between inmates of similar backgrounds.

Taft (LSC):

1. Type of Incident: Sexual Contact
2. Location: Housing Unit Restroom
3. Details: The Hispanic male inmate/victim reported to staff that another Hispanic male inmate touched him sexually on the buttock.
4. The incident occurred between inmates of similar backgrounds.

USP Tucson:

1. Type of Incident: Sexual Contact
2. Location: Recreation

3. Details: The Native American male inmate/victim reported to staff that a white male inmate touched him sexually by grabbing his testicles.
4. The incident occurred between inmates of differing backgrounds.

Substantiated Inmate-on-Inmate Assault Data				
Low Level Facility	Allegations	Substantiated	Problem Identified	Corrective Action
FCI Big Spring	3	1	No problems identified or recommendations made. The allegation was substantiated.	A thorough review of the incident was conducted. No physical barriers contributed or raised issues with monitoring technology. Staffing levels in the area were adequate as well.
FCI Ft. Dix	2	1	The physical layout of the facility, blind spots and physical barriers may have limited staff's ability to detect the abuse. Alleged sexual abuse was verified by an outside medical provider.	A thorough review of the incident was conducted. A recommendation was made to purchase and place cameras in general population housing units.
FCI Sandstone	1	1	No problems identified or recommendations made. The perpetrator admitted to touching the victim in his groin area.	A thorough review of the incident was conducted. No physical barriers contributed or raised issues with monitoring technology. Staffing levels in the area were adequate as well.
Taft (LSC)	1	1	No problems identified; however, one recommendation was made. The perpetrator admitted to touching the victim on the buttock.	A thorough review of the incident was conducted. A recommendation was made to purchase and place cameras in general population housing units.
Medium Level Facility	Allegations	Substantiated	Problem Identified	Corrective Action
FCI Otisville	2	1	No problems identified or recommendations made. The perpetrator admitted to touching the victim on the buttock.	A thorough review of the incident was conducted. No physical barriers contributed or raised issues with monitoring technology. Staffing levels in the area were adequate as well.

FCI Pekin	1	1	An incident review was not on file. The perpetrator admitted to touching the victim on the buttock.	Ensure staff are trained in the policy requirements regarding incident reviews.
High Level Facility	**Allegations**	**Substantiated**	**Problem Identified**	**Corrective Action**
USP Tucson	12	1	No problems identified or recommendations made. The perpetrator admitted to grabbing the victim's testicles.	A thorough review of the incident was conducted. No physical barriers contributed or raised issues with monitoring technology. Staffing levels in the area were adequate as well.
Administrative Facility	**Allegations**	**Substantiated**	**Problem Identified**	**Corrective Action**
FMC Carswell	8	1	An incident review was not on file. It should be noted the allegation was substantiated by video surveillance.	Ensure staff are trained in the policy requirements regarding incident reviews.
FDC Seatac	3	1	One concern was identified regarding the medical assessment process. The perpetrator admitted to touching the victim on his penis while he was showering.	The medical assessments of the male inmates were conducted by a female clinician, as no male clinicians were on duty at the time. Additional guidance will be provided regarding injury assessments being completed by same gender clinicians. In the event this is not possible, a staff member of the same gender as the inmates involved must be present during the examination.

IV. Staff-on-Inmate Incident-Based Assessment: Data for this category is provided in annual aggregate form. In addition, staff incidents are not part of the administrative record review for inmates and are received, assessed, and processed by the Office of Internal Affairs. Thus, facility security-level is not noted, and only the year-end totals are provided in this report. In comparison to last year's report, we are able to report the following trend: Staff-on-Inmate substantiated cases decreased from 21 to 9 (57%). We attribute this decrease to increased awareness of our zero tolerance policy regarding sexual abuse and harassment, an increase in guidance provided to our regional offices and field sites regarding the topic, and increased training in sexual abuse / harassment protocols provided to all staff in the BOP.

Staff-on-Inmate Incident-Based Data		
Facility	Number of Allegations	Number of Substantiated Cases
BOP	646	7 (1.1%)
LSC	31	2 (6%)

V. Assessment By Security Level (Inmate-on-Inmate) :

a. Sexual Abuse Allegations were made at the following rates:

Inmate-on-Inmate Allegations by Security Level Data

Security Level	Number of Institutions with Reported Allegations	Total Number of Institutions	Percentage of Reported Allegations by Security Level	Substantiated Inmate-on-Inmate
Minimum Level	0	7	0%	0
Low Level (Includes LSC Facilities)	22	44	50%	4
Medium Level	27	46	58.69%	2
High Level	12	16	75%	1
Administrative Level	14	20	70%	2
Grand Totals				
Total Facilities (Includes LSC Facilities)	75	133		9

Note:

•Minimum security level facilities are stand-alone camps; if an institution has a satellite camp or federal satellite low, the reporting numbers are combined.

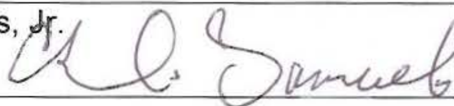
b. The rates at which the allegations are reported increases as the security level increases with the exception of the administrative level. Administrative facilities are institutions with special missions, such as the detention of pretrial offenders, the treatment of inmates with serious or chronic medical problems, or the containment of extremely dangerous, violent, or escape-prone inmates. These facilities are capable of housing inmates of all security levels. In comparison to CY2012, low, medium and administrative security level facilities saw an increase in reported allegations. There are no identifiable factors which caused the numbers to increase significantly at these three levels other than the fact data was collected for a full CY in 2013.

c. The majority of substantiated cases appear at lower level security facilities, a reverse trend from the previous calendar year report.

VI. Overview of Information:

a. A single factor does not appear to underlie the incidents reviewed above, nor did the incidents appear to have been 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.
b. The corrective action identified in last year's report seems to have been effective, as incident reviews were completed in seven of nine substantiated cases during CY2013. Staff training regarding PREA requirements and specialized training proved effective. The two facilities where an incident review did not occur were reminded of the policy requirement and both facilities subsequently completed the review.
c. Based on the locations in which the incidents occurred, physical layouts/barriers may have been a contributing in one of the nine incidents of inmate-on-inmate sexual abuse. It should be noted, in one of the nine incidents, technology served as supporting documentation to the allegation, as the incident was substantiated by video surveillance.
d. Staffing levels did not appear to have caused or contributed to the sexual abuse cases.

VII. Conclusion: Based on the review and findings noted throughout the report, it appears staff training regarding the requirement to complete inmate-on-inmate sexual abuse incident reviews has produced informative assessments.

Charles E. Samuels, Jr. Director 	DATE: 6-17-14