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

☐ Interim X☐ Final

Date of Report February 28, 2018

Auditor Information

K. E. Arnold	**kenarnold220@gmail.com**
K. E. Arnold, PREA Auditor	
P.O. Box 1872	**Castle Rock, CO 80104**
484-999-4167	**October 9-11, 2017**

Agency Information

Boyd Andrew Community Services		**NA**	
60 South Last Chance Gulch		**Helena, MT 59601**	
See above		**See above**	
406-443-2343		**Is Agency accredited by any organization?** ☐ Yes x☐ No	
The Agency Is:	☐ Military	☐ Private for Profit	**x**☐ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal
NA			
Agency Website with PREA Information: **boydandrew.com**			

Agency Chief Executive Officer

Amy Tenny	**CEO**
ATenny@boydandrew.com	**406-447-3281**

Agency-Wide PREA Coordinator

Brad Walter	**BACS PREA Coordinator**

BWalter@boydandrew.com	**406-560-0091**
PREA Coordinator Reports to: **Amy Tenny**	**Number of Compliance Managers who report to the PREA Coordinator 0**

Facility Information

Helena Pre-Release Center (HPRC)			
805 Colleen Street Helena, MT 59601			
Mailing Address (if different than above): NA			
406-443-2343			
The Facility Is:	☐ Military	☐ Private for Profit	x☐ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

Facility Type:	☐ Community treatment center	☐ Halfway house	☐ Restitution center
	☐ Mental health facility	☐ Alcohol or drug rehabilitation center	
	X☐ Other community correctional facility		

Facility Mission: Promoting public safety and rehabilitation with consistent supervision and utilization of Evidence-Based Practices in areas of Addiction Treatment, Mental Health Services, Case Management Services, and Employment Services to successfully reintegrate offenders into society.
Facility Website with PREA Information: boydandrew.com
Have there been any internal or external audits of and/or accreditations by any other organization? **x**☐ Yes ☐ No

Director

Name: Devin McGee	**Title:** Program Director (PD)
Email: dmcgee@boydandrew.com	**Telephone:** 406-447-3277

Facility PREA Compliance Manager

Name: Devin McGee	**Title:** PD
Email: dmcgee@boydandrew.com	**Telephone:** **406-447-3277**

Facility Health Service Administrator			
Name: Jennifer Murfitt		Nursing Supervisor	
E-mail: cm13@boydandrew.com		**Telephone:** 406-447-3285	
Facility Characteristics			
Designated Facility Capacity: 104		**Current Population of Facility:** 100	
Number of residents admitted to facility during the past 12 months			185
Number of residents admitted to facility during the past 12 months who were transferred from a different community confinement facility:			71
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 30 days or more:			181
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:			185
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:			0
Age Range of Population:	x☐ Adults 18 and up	x☐ Juveniles 0	x☐ Youthful residents 0
Average length of stay or time under supervision:			192 days
Facility Security Level:			Community Based/Open/Minimum
Resident Custody Levels:			Community Based/Open/Minimum
Number of staff currently employed by the facility who may have contact with residents:			25
Number of staff hired by the facility during the past 12 months who may have contact with residents:			16
Number of contracts in the past 12 months for services with contractors who may have contact with residents:			1 contract with 2 employees
Physical Plant			
Number of Buildings: 1		**Number of Single Cell Housing Units:** 0	
Number of Multiple Occupancy Cell Housing Units:		48	

Number of Open Bay/Dorm Housing Units:	0
Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.): See auditor's narrative in Facility Characteristics section.	
Medical	
Type of Medical Facility:	Nurses Office
Forensic sexual assault medical exams are conducted at:	St. Peter's Hospital in Helena, MT
Other	
Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:	Three volunteers and two contract employees.
Number of investigators the agency currently employs to investigate allegations of sexual abuse:	Four HPRC PREA Investigators- administrative investigations. Helena Police Department- criminal investigations.

Audit Findings

Audit Narrative

The Prison Rape Elimination Act (PREA) on-site audit of the Helena Pre-Release Center (HPRC) was conducted October 9-11, 2017 by K. E. Arnold from Castle Rock, CO, a United States Department of Justice Certified PREA Auditor for both juvenile and adult facilities. Pre-audit preparation included review of all materials and self reports electronically uploaded to an encrypted thumb drive and mailed to the auditor's address via special mail service. The thumb drive was securely packaged in such a manner as to alert to envelope tampering.

The documentation reviewed included, but was not limited to, agency and facility policies, staff training slides, completed forms regarding both staff and resident training, MOUs, organizational chart(s), a PREA brochure, the PREA video presented to offenders, offender education materials, photographs of PREA related materials (e.g. posters, etc.), executed Human Resources documents associated with relevant PREA standard(s), and staff training certifications. This review prompted several questions and informational needs that were addressed with the Boyd Andrews Community Services (BACS) PREA Coordinator. The majority of informational needs were addressed pursuant to telephonic contact and receipt of scanned documents.

At approximately 8:00AM on October 9, 2017, the auditor met with the BACS Chief Operating Officer (COO), the HPRC Program Director (PD), and the BACS PREA Coordinator. The auditor provided an overview of the audit process and advised all attendees the same would be facilitated in the least disruptive manner possible. Additionally, the auditor advised attendees of the tentative schedule(s) for the conduct of the audit.

During the on-site audit, the auditor was provided a private conference room from which to review documents and facilitate confidential interviews with staff and residents. The auditor randomly selected (from a resident roster provided by the BACS PREA Coordinator) and interviewed 19 residents (with varying lengths of stay) on-site pursuant to the Random Sample of Residents Questionnaire. Resident interviewees represented the three housing unit wings at HPRC.

According to the HRPC PD and BACS PREA Coordinator, there were no resident(s) confined in the facility at the time of the on-site audit, who reported a sexual abuse incident during the audit period. Similarly, there were no resident(s) confined in the facility during the on-site audit who were Limited-English Proficient (LEP) or transgender/intersex residents.

It is noted the 19 random resident interviewees were generally questioned regarding their knowledge of a variety of PREA protections and their knowledge of reporting mechanisms available to residents for reporting sexual abuse and sexual harassment. Overall, random resident interviewees presented knowledge of PREA policies and practices. Of note, the auditor inquired as to the basis for their knowledge

and random residents advised they had received training by HPRC staff however, they have also received training at other Montana Department of Corrections facilities and/or other Pre-Release Centers, treatment facilities, etc. throughout the State of Montana. Additionally, all 19 random resident interviewees advised they feel sexually safe at HPRC.

Twelve random staff selected by the auditor from a staff roster provided by the HPRC PD and BACS PREA Coordinator, were interviewed. The Random Sample of Staff Interview Guide was administered to this sample group of interviewees. Interviewees were questioned regarding PREA training and overall knowledge of the agency's zero tolerance policy, reporting mechanisms available to residents and staff, the response protocols when a resident alleges sexual abuse, and First Responder duties.

The following specialty staff questionnaires were utilized during this review including:

Agency Head
Warden or Designee
PREA Coordinator
Designated Staff Charged with Monitoring Retaliation
Incident Review Team
Human Resources
Investigator (2)
SAFE/SANE
Intake
Staff Who Perform Screening for Risk of Victimization and Abusiveness (2)
Security and Non-Security Staff Who Have Acted as First Responders (7)
Non-medical Staff Involved in Cross-Gender Strip or Visual Searches
Medical
Mental Health
Contractor

As a contract administrator is not employed by BACS, that interview was not conducted.

It is noted BACS is the umbrella company for HPRC.

The following resident interviews were facilitated in addition to the random resident interviews. The interview sets are noted below:

LGBTI (2)
Resident(s) with Disabilities (2)

The auditor reviewed 10 Staff Training records, 10 resident files, eight (8) staff HR files, 1 PREA investigative file, and other records reflected throughout the following narrative, prior to the audit, during the audit, and subsequent to completion of the same.

On October 9, 2017, the auditor was processed into the facility at the Control Center (bubble). As mentioned in 115.211, a PREA Compliance Acknowledgment is issued to all contractors, visitors, and volunteers each time they enter HPRC. Potential entrants (inclusive of the auditor) are instructed to read this Acknowledgment and affix their signature to the same. The Acknowledgment addresses definitions of sexual abuse, sexual harassment, and voyeurism and mandatory investigation of anyone who has allegedly committed such an act, inclusive of prosecution in those instances wherein the threshold is met for a criminal act. Additionally, the same includes a certification of understanding of the requirements of PREA as scripted in the document, verbiage regarding zero tolerance towards any form of sexual abuse and sexual harassment, and verbiage regarding immediate reporting of any knowledge of sexual abuse or sexual harassment. This document serves as a constant PREA reminder to affected individuals entering the confines of BTC. When signing this document, contractors, vendors, service providers, volunteers, and visitors of HPRC are likewise certifying they have familiarized and understand PREA, agreeing to abide by this law.

From 9:00AM to 10:45AM on the same date, the HPRC PD, the BACS PREA Coordinator, and the auditor toured the entire facility. The auditor observed, among other features, the facility configuration, location of cameras, staff supervision of offenders, wing layout (inclusive of shower/toilet areas), placement of PREA posters and informational resources, security monitoring, and offender programming.

Pursuant to contact with the Shelter Administrator at Safe Space, the auditor has determined no HPRC sexual abuse/harassment allegations were received between the dates of October 9, 2016 and October 9, 2017.

Facility Characteristics

HPRC is a community corrections 105-bed facility serving adult men who must be a resident of Montana. The facility is designed to ease the transition of an offender from a correctional institution to living independently in the community. A person may be transferred from a jail directly to the Center (on inmate status) if the Montana Department of Corrections determines the offender does not need to go to prison and/or the offender violated conditions of their community placement.

The BACS and HPRC executive staff believe the four most important areas to focus on during rehabilitation are:

- **Employment** – it can be a source of pride, identity, and the beginning of financial security
- **Education** – is a transition to a better, criminal-free future lifestyle
- **Treatment** – a drug-free and emotionally stable person will be able to get and stay well
- **Connections –** with family and supportive friends to ease your transition back to a satisfying life

Combined with the state-of-the-art facility, a diverse and knowledgeable staff, and supportive community, staff will continue to lead the way for bringing a better tomorrow closer today.

Employment Programming

"*Get back on my feet", "Find a job", "Make a living"* are frequent requests heard from residents. A job can be a source of pride, identity and the beginning of financial security. HPRC full-time job coordinators network with the greater Helena community to find employment opportunities for residents. In a recent period, the average time to find employment for residents was between 7-10 days.

Educational programming

A transition to a better future requires new approaches. Education and instruction in life skills and job preparation are provided with a long-term focus. Assistance from the Helena Adult Learning Center and CTI (Career Training Institute) includes completion of the GED and other educational opportunities.

Treatment programming

A diverse staff delivers a myriad of treatment programs to facilitate a healthy transition to the community. Expertise in chemical dependency, job development, and care management enable staff to respond to resident needs. A part-time psychologist adds to the ability to further the emotional and psychological wellness of residents.

The following specialized services are offered:

- Chemical dependency and mental health evaluations
- Intensive outpatient addiction treatment (up to 10 hours of services per week)
- Outpatient addiction treatment (1 to 3 hours per week)
- Cognitive behavioral therapies such as;
    - Strategies for Self-Improvement and Change
    - Cognitive Principles & Restructuring
    - Anger Management
- Parenting classes
- Victim Impact Panel

Connectedness

The appeal of a pre-release center is the progressive transition back to a satisfying life and to reestablish connections with family and friends. The pleasant environment with easy access, parking, and contemporary setting encourages a positive return to normalcy. The network between the center and skilled professionals, schools, and community agencies is the resident's connection to a better future.

HPRC is comprised of one building with an Administrative Area located on the South side of the building and leading to the bubble. Three male housing unit wings (A, B, and C) are located north and rounding east of the bubble. The bubble is open (half wall) on sides exposed to the housing unit wings. Staff offices and program areas (surveilled by camera located in the hallway) are located downstairs in B Wing. Two cameras are strategically located at the top of the stairs leading to the staff offices, capturing any traffic headed downstairs. Residents are not authorized to be in the bubble and the same is manned on a 24/7 basis.

Throughout the tour, the auditor observed numerous PREA posters in housing units, program areas, Food Service, staff offices/gathering places. Clearly, residents have access to continual education regarding PREA processes. Additionally, PREA Audit Notices were generously posted throughout the facility.

Providing an overview of camera surveillance, the auditor counted approximately 34 cameras at HPRC. Cameras are strategically located to cover resident and staff entrance and egress from the facility and most points throughout the same. Outside entrances appear to be adequately covered with surveillance, as well as, stairwells. Three cameras cover the exterior of the Administrative Area and one camera covers the door leading to the bubble and visiting area.

The indoor visiting area is covered by one camera while another camera covers an egress door to the area. However, two cameras located inside the bubble also provide some coverage in the visiting area.

One camera is positioned outside the bubble, covering each wing. While the camera captures much of each wing, clarity decreases as one traverses past the one-half to three-quarters part of the same. Any camera addition considerations should include the back of each wing.

While bathrooms and laundry are in the line of site of both cameras and staff, there are no cameras in bathrooms. Likewise, there are no cameras in resident rooms. There is a camera in the laundry.

Bathrooms are comprised of four shower stalls, inclusive of one handicap shower, covered by shower curtains. Reportedly, female staff don't enter bathrooms during count. They ask who is in the shower/bathroom.

The food service area dining area is monitored by three cameras. One camera (oscillating) monitors the Food Preparation Area. There are some blind spots in the area which also warrant consideration for additional cameras. Of note, meals are produced by MDOC (quick chill) and transported to HPRC.

Two cameras surveil the smoking area located outside B Wing. Additionally, the recreation yard door is covered by a camera.

Cameras are monitored from both the bubble and Security Coordinator's Office.

It is noted that resident room doors, bathroom doors, and mop closet doors are solid. There are windows in each staff door.

There is an Emergency Grievance Box located in the building. The same is checked twice daily, seven days per week. Reportedly, the Emergency Grievance Box and location of the same are addressed during Orientation.

The HPRC is a busy facility with substantial movement on a daily basis. Resident movement to and from work in the community, programs, and community activities is abundant and appears to be monitored and tracked in an effective manner.

Summary of Audit Findings

Number of Standards Exceeded:

The auditor found HPRC to exceed standards expectations with respect to Standards 115.211, 115.215, 115.231, 115.273, and 115.286. A narrative justifying the finding is included below.

The auditor finds Standard 115.211 to exceed standard as articulated in the narrative. Specifically, upon entrance to HPRC, a PREA Compliance Acknowledgment is issued to all contractors, visitors, and volunteers each time they enter HPRC. Potential entrants (inclusive of the auditor) are instructed to read this Acknowledgment and affix their signature to the same. The Acknowledgment addresses definitions of sexual abuse, sexual harassment, and voyeurism and mandatory investigation of anyone who has allegedly committed such an act, inclusive of prosecution in those instances wherein the threshold is met for a criminal act. Additionally, the same includes a certification of understanding of the requirements of PREA as scripted in the document, verbiage regarding zero tolerance towards any form of sexual abuse and sexual harassment, and verbiage regarding immediate reporting of any knowledge of sexual abuse or sexual harassment. This document serves as a constant PREA reminder to affected individuals entering the confines of BTC. When signing this document, contractors, vendors, service providers, volunteers, and visitors of HPRC are likewise certifying they have familiarized and understand PREA, agreeing to abide by this law.

Standard 115.215 has been found to exceed standard as ALL cross-gender pat searches are documented. Pursuant to the Pre-Audit Questionnaire (PAQ), the PD self reports facility policy requires that all cross-gender strip searches and cross-gender visual body cavity searches are documented. As previously indicated, female residents are not housed at HPRC and accordingly, documentation of pat searches of female residents is not applicable to HPRC.

HPRC Policy 3.1 entitled PREA General Requirements, page 8, section IV(A)(9) addresses 115.215(c). Although there are no female residents housed at HPRC, ALL cross-gender pat searches are logged in the Exigent Circumstances Log. This includes female staff pat searches of male residents. Specifically, this policy stipulates staff will document any cross-gender strip searches and cross-gender visual body cavity searches, and documents all cross-gender pat-down searches in the exigent circumstances log. This policy (regarding documentation of all cross-gender pat searches, inclusive of such searches of male residents) clearly exceeds the provision language.

The auditor finds HPRC exceeds standard expectations with respect to Standard 115.231. Specifically, pursuant to the auditor's review of several training files during the PAQ process, he determined that nearly all staff files (25 of 26) contained one or more PREA on-line courses presented by the National

Institute of Corrections, the Moss Group, or outside vendors or receipt of programs from MDOC. Clearly, the HPRC leadership and staff have embraced PREA sexual safety training, signifying above and beyond standard expectations with respect to this critical area. Accordingly, the auditor has determined HPRC staff have exceeded this standard.

HPRC exceeded standard expectations with respect to Standard 115.273. HPRC Policy 3.10 entitled Investigations, page 3, section III(A) addresses 115.273(a). This policy stipulates following an investigation into a resident's allegation of sexual abuse/sexual harassment in the facility, the Program Administrator informs the resident of the findings-whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded.

As previously indicated, the auditor did review the sexual harassment investigation referenced in 115.271 and found the PD did inform the alleged victim, in writing, that the sexual harassment investigation had been determined to be unsubstantiated. The memorandum was dated August 24, 2017.

It is noted the standard provision applies only to allegations of sexual abuse suffered in an agency facility. The HPRC addresses reporting to the alleged victim of both sexual abuse and sexual harassment. Clearly, the policy and implementation of the same exceeds standards expectations. Accordingly, the auditor finds that HPRC exceeds Standard 115.273.

The auditor finds HPRC exceeded expectations relative to Standard 115.286. Specifically, HPRC Policy 3.7 entitled Data Collection, Aggregation, and Review, page 1, section II(A)(1)(a) addresses 115.286(a). This policy stipulates HPRC shall conduct a sexual abuse incident review at the conclusion of every criminal or administrative sexual abuse or sexual harassment investigation including whether the allegation has not been substantiated, unless the allegation has been determined to be unfounded. The review will include all members of the Sexual Assault Review Team (SART).

The auditor reviewed the HPRC SART Checklist regarding the "Unsubstantiated" sexual harassment investigation completed on August 24, 2017. This investigation was elaborated upon in 115.271. The auditor finds the SART Review was conducted commensurate with all provisions of 115.286.

Given the fact 115.286(a) addresses the conduct of SART reviews at the conclusion of every sexual abuse investigation, unless the allegation is determined to be "Unfounded", the auditor finds HPRC exceeds the provision and standard by virtue of policy and practice. Specifically, the afore-mentioned policy also requires the conduct of a SART review in the case of a "Substantiated" or "Unsubstantiated" sexual harassment investigation. The completed SART review in this matter and accompanying recommendation signifies the commitment of BACS and HPRC to the enhancement of sexual safety at the facility.

Number of Standards Met:

The auditor found that 31 standards were substantially compliant with the articulated standards. **Following a period of corrective action and review of substantiating evidence, the auditor now finds 34 standards are now substantially compliant.** These standards have been found to Meet Requirements.

Number of Standards Not Met:

In regard to provisions 115.217(a), (b), (c), and (f), the auditor finds HPRC to be non-compliant. A narrative regarding these findings and proposed corrective actions follows.

Pursuant to the PAQ, the PD self reports agency policy prohibits hiring or promoting anyone who may have contact with residents and prohibits enlisting the 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);
• 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; or
• Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section.

BACS Personnel Manual 2017, page 85, section entitled Recruitment addresses 115.217(a). This policy stipulates applicants who have engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution; have 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; or have been civilly or administratively adjudicated to have engaged in the activity described above shall be considered unsuitable for employment with Boyd Andrew Community Services.

In addition to the above, BACS Policy 1.3.5.12 entitled PREA Policy, page 7, section 217(a) addresses 115.217(a). This policy stipulates BACS shall not hire or promote anyone who may have contact with residents, and shall not enlist the services of any contractor who may have contact with residents, who—(1) 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); (2) 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; or (3) Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section.

The auditor reviewed interview questions for all positions falling under the umbrella of BACS facilities management. All interview question sets contain the questions set forth in 115.217(a). These same questions, as well as, the afore-mentioned questions germane to 115.217(a) are asked during promotion interviews, according to the PREA Coordinator.

The auditor was provided interview notes addressing these three questions for one of three interviewees. There is no evidence reflecting these questions are asked on the employment application.

Finally, the auditor inquired regarding one individual who was promoted during the past year and was advised he/she was appointed. There was no application phase or promotion interview.

In regard to contractors, the auditor has not been provided any evidence substantiating compliance with 115.217(a).

In view of the above, the auditor finds HPRC is non-compliant with 115.217(a). Specifically, there is a lack of evidence to prove substantial compliance with the provision.

In an effort to certify compliance with this provision, it is recommended the BACS PREA Coordinator will provide completed copies of prior employment reference checks bearing a response to the three questions articulated in this provision for both applicants and contractors. The document will reflect the date of the response, the responding employer's name and signature, the applicant's name, and the position he/she seeks. If the reference check is accomplished via telephone, the hiring manager will ensure the same information is reflected on the document. It is recommended the BACS PREA Coordinator develop a form which adequately captures the above, as well as, the specific statements of the former employer in response to the questions.

As previously mentioned, interview forms reflect a question regarding the requisite three questions as articulated in 115.217(a). This form will need to be revised to include the information articulated in the preceding paragraph. The BACS PREA Coordinator will provide completed copies of interview notes to the auditor relative to new hires, promotion applicants, as well as, any contractor(s).

HPRC will have to capture responses to the three questions during the promotion process, as previously described. A copy of the appointment letter (or equivalent thereof) or promotion letter will assist the auditor in assessing whether the promotion applicant's responses to the three questions were considered in the hiring/promotion decision. Accordingly, this document must also be included in the packet forwarded to the auditor.

Given the complexity of the above, training of hiring managers regarding these procedures will be essential. Institutionalization and inclusion into the facility culture will be accomplished pursuant to training, repetition, and monitoring. Accordingly, the BACS PREA Coordinator will also forward copies of training sheets regarding this matter to the auditor.

This process must be completed on or before April 24, 2018 to ensure the auditor can conclude review and assessment of corrective action prior to corrective action period closure. This provision can be closed prior to the afore-mentioned date based on the auditor's assessment.

Pursuant to the PAQ, the PD self reports agency policy requires the consideration of any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.

BACS Policy 1.3.5.12 entitled PREA Policy, page 7, section 115.117(b) addresses 115.217(b). This policy stipulates BACS shall consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.

According to the Human Resources staff interviewee, the facility considers prior incidents of sexual harassment when determining whether to hire or promote anyone, or to enlist the services of any contractor who may have contact with residents. The interviewee asserts that a sexual harassment question is included in the reference check (vetting) questionnaire.

According to the BACS PREA Coordinator and evidence presented, there is only one file of four wherein evidence reflects that previous institutional employers were questioned regarding incidents of sexual harassment of residents/inmates/etc. during the applicant's previous employment. Specifically, while applicants were reference checked, records/notes were either not maintained or were subsequently destroyed.

In addition to the above, there is no evidence reflecting that applicants/interviewees were questioned about the existence of sexual harassment of confined individuals during their previous work history. The BACS PREA Coordinator reports that all interview question sheets (used during employment and promotion interviews) have been updated to include this question.

It is also noted the auditor has not been provided any evidence regarding this matter as applied to contractors.

In view of the above, the auditor finds HPRC to be non-compliant with this provision. In an effort to certify compliance with this provision, the BACS PREA Coordinator will provide completed copies of prior institutional employment reference checks bearing a response to the sexual harassment question for both applicants and contractors. The document will reflect the date of the response, the responding employer's name and signature, the applicant's name, and the position he/she seeks. If the reference check is accomplished via telephone, the hiring manager will ensure the same information is reflected on the document. It is recommended that the BACS PREA Coordinator develop a form which adequately captures the above, as well as, the specific statements of the former employer in response to the questions.

As previously mentioned, interview forms have been revised to add a question regarding sexual harassment of residents, inmates, etc. during the applicant's work history. This form will need to be revised to include the information articulated in the preceding paragraph. The BACS PREA Coordinator will provide completed copies of interview notes to the auditor relative to new hires, promotion applicants, as well as, any contractor(s).

A copy of the appointment letter (or equivalent thereof) or promotion letter will assist the auditor in assessing whether the prevalence of sexual harassment was considered in the hiring/promotion decision. Accordingly, this document must also be included in the packet forwarded to the auditor.

Given the complexity of the above, training of hiring managers regarding these procedures will be essential. Institutionalization and inclusion into the facility culture will be accomplished pursuant to training, repetition, and monitoring. Accordingly, the BACS PREA Coordinator will also forward copies of training sheets regarding this matter to the auditor.

This process must be completed on or before April 24, 2018 to ensure the auditor can conclude review and assessment of corrective action prior to corrective action period closure. This provision can be closed prior to the afore-mentioned date based on the auditor's assessment.

Pursuant to the PAQ, the PD self reports agency policy requires that before it hires any new employees who may have contact with residents, it (a) conducts criminal background record checks, and (b) consistent with federal, state, and local law, makes 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. The PD further self reports there were 16 staff hired during the past 12 months (100%) who may have contact with residents have had criminal background record checks.

BACS Personnel Manual 2017, page 84, section entitled Recruitment addresses 115.217(c). This policy stipulates applicants shall be required to consent to a criminal background check as related to CFR 115.217. Failure to provide consent or the existence of a criminal background deemed non-compliant with current federal code will result in disqualification from consideration for employment.
BACS Policy 1.3.5.12 entitled PREA Policy, page 8, section 115.217(c) addresses 115.217(c). This policy stipulates before hiring new employees who may have contact with residents, BACS shall: (1) Perform a criminal background records check; and (2) 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.

Four of the four criminal background records checks reviewed were completed prior to the hire date of the employees. None of these documents reflected any offenses as reflected in 115.217(a).

In regard to reference check documents with previous institution employers regarding these same four staff, the auditor received one such document. While the BACS PREA Coordinator asserts multiple telephonic requests were made regarding another of these employees, calls were reportedly not returned. Additional contact with individuals at the location resulted in irrelevant information. No evidence substantiating the calls forwarded to the employer was provided to the auditor.

In view of the above, the auditor finds HPRC to be non-compliant with 115.217(c). Much like the corrective action articulated in the narrative for 115.217(b), the BACS PREA Coordinator will forward to the auditor copies of the documents forwarded to previous institutional employers regarding substantiat-

ed allegations of sexual abuse or any resignation pending investigation of an allegation of sexual abuse, as well as the previous employer's response, for a period not to exceed April 24, 2018. All requirements as articulated in the narrative for 115.217(a) and (b) likewise apply to this provision.

BACS Policy 1.3.5.12 entitled PREA Policy, page 8, section 115.217(f) addresses 115.217(f). This policy stipulates BACS shall also 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 and in any interviews or written self-evaluations conducted as part of reviews of current employees. BACS shall also impose upon employees a continuing affirmative duty to disclose any such misconduct.

According to the Human Resources interviewee, applicants and employees who have contact with residents are asked about previous misconduct described in 115.217(a) in written applications for hiring or promotions, and in any interviews or written self-evaluations conducted as part of reviews of current employees. The interviewee was uncertain as to the duration of the practice. The questions were asked in a recent interview conducted at HPRC.

In addition to the above, the interviewee asserts the facility imposes upon employees a continuing affirmative duty to disclose any such previous misconduct as described in the narrative for 115.217(a).

The auditor has not been provided any substantiating evidence with respect to application questions regarding the three issues articulated in 115.217(a). Additionally, as previously indicated, the one employee promoted during the past 12 months was appointed and therefore did not participate in an interview. Accordingly, no substantiating evidence has been provided regarding the requirements of this provision being implemented during a promotion interview. Finally, the auditor has not been provided any substantiating evidence proving that staff are asked the three questions articulated in 115.217(a) during written self-evaluations conducted as part of performance reviews.

In view of the above, the auditor finds HPRC to be non-compliant with 115.217(f). As corrective action, it is recommended the BACS PREA Coordinator develop a form reflecting the three questions articulated in 115.217(a). The form will reflect the prospective employee's, promotion interviewee's, and the employee participating in the performance evaluation process, printed name/signature, and the date of execution. Additionally, a signature line should be available for the supervisory witness. This form can be utilized during the interview and performance appraisal process.

In addition to the above, the employment application must be changed to reflect the three questions articulated in 115.217(a) and whether the applicant has committed them or received some form of judgment for such actions. The revised application must be used henceforth.

Corrective action regarding employment/promotion interviews is discussed in the narrative for 115.217(a).

Upon completion of these tasks, the BACS PREA Coordinator and/or Business Manager must provide training to hiring managers regarding the performance evaluation change, and all staff regarding the employment application/interview changes. Copies of the training records for the issues described above, will be forwarded to the auditor for review. Additionally, copies of completed employment and promotion (if applicable) applications and completed copies of the proposed new form to be used during interviews and performance review discussions, etc., will be forwarded to the auditor for review.

This process must be completed on or before April 24, 2018 to ensure the auditor can conclude review and assessment of corrective action prior to corrective action period closure. This provision can be closed prior to the afore-mentioned date based on the auditor's assessment.

The auditor also found HPRC to be non-compliant with Standards 115.232, and 115.241. A narrative substantiating the findings, as well as, corrective action steps and due dates follows.

In regard to 115.232, the PD self reports the agency maintains documentation confirming that volunteers/contractors understand the training they have received.

HPRC Policy 3.6 entitled Training, page 2, section II(F) addresses 115.232(c). This policy stipulates the HPRC Program will maintain documentation confirming volunteers and contractors understand the training they have received.

Pursuant to contact with the BACS PREA Coordinator, HPRC does not possess training documentation verifying that volunteers and contractors understand the What You Need to Know video and Zero Tolerance et. al. training. Accordingly, HPRC is not in compliance with this standard provision.

To ensure compliance with this provision, a new form bearing the "I understand" caveat has been implemented for contractor and volunteer training. Pursuant to agreement between the PREA Coordinator and the auditor, the PREA Coordinator will use this form henceforth subsequent to provision of requisite training. Additionally, he will ensure that all current contractors/volunteers execute this form, subsequently forwarding copies of the same to the auditor. The PREA Coordinator has already commenced this process and the auditor has received numerous executed forms.

This process must be completed on or before April 24, 2018 to ensure the auditor can conclude review and assessment of corrective action prior to corrective action period closure (180 days from the date of this report). This provision can be closed prior to the afore-mentioned date based on the auditor's assessment.

In regard to 115.241, the PD self reports policy requires that the facility reassess each resident’s risk of victimization or abusiveness within a set time period, not to exceed 30 days after the resident’s arrival at the facility, based upon any additional, relevant information received by the facility since the intake screening. The PD further self reports 68 residents (since March, 2017) have entered the facility (either through intake or transfer) who were reassessed for their risk of sexual victimization or of being sexually

abusive within 30 days after their arrival at the facility based upon any additional, relevant information received since intake.

HPRC Policy 3.3 entitled Intake/Screening, page 4, section II(B)(3) addresses 115.241(f). This policy asserts within a set time period, not to exceed 30 days from the Resident's arrival at the facility, the facility's Chemical Dependency Counselor will reassess the Residents' risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening.

The auditor reviewed 24 Initial PREA Assessments with the accompanying Re-Assessments and determined 12 of the PREA Re-Assessments were facilitated outside the 30-day maximum threshold from the date on which the Initial PREA Assessment was conducted. Seven of the 12 Re-Assessments were facilitated within 31 or 32 days of the Initial PREA Assessment. The remaining five Re-Assessments were conducted within 34 to 45 days of the date of the Initial PREA Assessment.

Of the 19 random resident interviewees, five residents assert they received a re-assessment. Two interviewees assert they do not recall and three interviewees stated they didn't think they received a re-assessment. Nine interviewees assert they did not receive a PREA re-assessment.

The auditor reviewed nine resident files, as described in the following paragraph, related to these residents. Of those residents who advised they did not have a re-assessment, the auditor found that one did have a re-assessment, two did not have a re-assessment, and two received an untimely re-assessment. Of those that did not recall if they had a re-assessment, one did not have a re-assessment. Of those that didn't think they had a re-assessment, two did have a timely re-assessment while one had an untimely re-assessment.

During the HPRC on-site audit, the auditor reviewed 10 resident files and determined there was no re-assessment in four cases and the re-assessment was untimely in three additional cases.

In view of the above, provision 115.241(f) has been determined to be non-compliant. Given the tracking procedure currently implemented, the auditor finds that corrective action should be accomplished in an expeditious fashion.

Corrective action is comprised of the steps as follows. The BACS PREA Coordinator will forward a roster of dates of arrival for the next three to five months to the auditor. Additionally, copies of the corresponding re-assessment forms will likewise be forwarded to the auditor for review and comparison. A copy of the Initial PREA Assessment will also be included in this packet.

This process must be completed on or before April 24, 2018 to ensure the auditor can conclude review and complete an assessment of corrective action prior to corrective action period closure. As mentioned above, this provision can be closed prior to the afore-mentioned date based on the auditor's assessment.

Note: Corrective action and associated documents are discussed in the narratives for the affected non-compliant standards. The auditor now finds HPRC to be compliant with the PREA Standards for Community Confinement Facilities.

Summary of Corrective Action (if any)

The summary of corrective action accompanies the objective findings as identified in the preceding section.

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

115.211 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator? x□ Yes □ No
- Is the PREA Coordinator position in the upper-level of the agency hierarchy? x□ 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? x□ Yes □ No

Auditor Overall Compliance Determination

x☐ **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*)

Pursuant to the PAQ, the Program Director (PD) self reports the agency has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment in facilities it operates directly or under contract. The PD further self reports the facility has a written policy outlining how it will imple-

ment the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. This policy includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment. Additionally, this policy includes sanctions for those found to have participated in prohibited behaviors. Finally, this policy includes a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents.

HPRC Policy 3.1 entitled PREA General Requirements, pages 1-9, addresses 115.211(a). The auditor finds this policy to be quite comprehensive and clearly commensurate with provision expectations.

Upon entrance to HPRC, a PREA Compliance Acknowledgment is issued to all contractors, visitors, and volunteers each time they enter HPRC. Potential entrants (inclusive of the auditor) are instructed to read this Acknowledgment and affix their signature to the same. The Acknowledgment addresses definitions of sexual abuse, sexual harassment, and voyeurism and mandatory investigation of anyone who has allegedly committed such an act, inclusive of prosecution in those instances wherein the threshold is met for a criminal act. Additionally, the same includes a certification of understanding of the requirements of PREA as scripted in the document, verbiage regarding zero tolerance towards any form of sexual abuse and sexual harassment, and verbiage regarding immediate reporting of any knowledge of sexual abuse or sexual harassment. This document serves as a constant PREA reminder to affected individuals entering the confines of BTC. When signing this document, contractors, vendors, service providers, volunteers, and visitors of HPRC are likewise certifying they have familiarized and understand PREA, agreeing to abide by this law.

The auditor finds this strategy to be above and beyond in terms of HPRC's efforts to educate and enhance knowledge of the PREA statutes, reporting options, and HPRC's commitment to zero tolerance with respect to sexual abuse/sexual harassment of residents. Essentially, all entrants, aside from HPRC staff, participate in this valuable exercise.

Pursuant to the PAQ, the PD self reports the agency employs or designates an upper-level, agency-wide PREA coordinator. The PD further self reports the PREA coordinator has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its community confinement facilities.

The auditor has reviewed the Boyd Andrew Community Services (BACS) Organizational Chart and finds that the BACS PREA Coordinator falls directly under the supervision of the BACS Chief Executive Officer (CEO). Accordingly, this is commensurate with the standard provision expectations.

The PREA Coordinator advises he has sufficient time to manage all of his PREA- related responsibilities. He relates he discusses PREA issues with both the PD and Chief Operating Officer (COO) at Helena Pre-Release Center (HPRC) and Elkhorn Treatment Center (ETC). Shortcomings are identified and addressed. He assumes a lead role in PREA policy development, conducts PREA investigations, conducts PREA training, addresses any PREA- related questions or inquiries, and is included in the loop when PREA issues or incidents arise. He asserts he maintains a close working relationship with the facility administrators at both facilities.

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 x□ NA

115.212 (b)

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to a memorandum (memo) dated July 12, 2017, authored by the PD, HPRC does not contract with other agencies for the confinement of residents. Since the agency does not contract with other agencies, the auditor finds HPRC to be compliant with the standard.

Standard 115.213: Supervision and monitoring

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

115.213 (a)

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

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

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

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

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

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

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

Auditor Overall Compliance Determination

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

Pursuant to the PAQ, the PD self reported that for each facility, the agency develops and documents a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring to protect residents against sexual abuse. Since August 20, 2012, the average daily number of residents has been 101 and the average daily number of residents upon which the Staffing Plan is predicated is 104.

HPRC Policy 3.1, page 7, section IV(A)(5) addresses 115.213(a). This policy asserts HPRC has developed and documented an annual staffing plan approved by the corporate office that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against sexual abuse. In calculating adequate staffing levels and determining the need for video monitoring, the staffing plan takes into consideration:
The physical layout of the facility including any blind spots;
The composition of the resident population;
The prevalence of substantiated and unsubstantiated incidents of sexual abuse and;
Any other relevant factors.

The auditor reviewed the Staffing Plan dated March 24, 2017, and signed by the PD, finding the same to be in compliance with the requirements of 115.213(a).

Pursuant to interview with the PD, he relates there is a staffing plan at HPRC and there is an adequate staffing level to protect residents against sexual abuse, video monitoring is considered in this plan, and the staffing plan is documented. An electronic copy of the plan is maintained in the PD's Office.

The Staffing Plan was originally created pursuant to company and Montana Department of Corrections (MDOC) guidelines. The composition of the resident population is considered based on the nature of the offenses reflected in the population and information gleaned from Intake/classification documents. Substantiated and unsubstantiated incidents of sexual abuse are considered, as well as, location(s) of the incident(s), whether the area was captured on camera surveillance, staff presence, etc.

In regard to monitoring compliance with the staffing plan, the PD relates he reviews all time sheets and evaluates who is calling off. Staff must report to their supervisor. Generally, the PD approves overtime. At times, we'll use other positions (e.g. Case Managers, etc.) to fill vacancies. The PD receives an e-mail regarding call offs , etc. and fill behind needs. Posts never remain vacant.

When assessing adequate staffing levels and the need for video monitoring, the BACS PREA Coordinator advises obstructions, line of sight, and blind spots are considered for camera placements or staff as-

signments. Population considerations in terms of staffing plan compilation are race, age, trauma history, mental health history (whether to increase mental health staffing), and contentious issues associated with nature of offense or Security Threat Groups (STGs). In regard to the prevalence of substantiated and unsubstantiated incidents of sexual abuse, trends would be researched/identified and resources allocated/ increased to offset deficient areas or perceived deficient areas. Finally, any factor that manifests itself would be considered.

Pursuant to the PAQ, the PD self reports that each time the staffing plan is not complied with, the facility documents and justifies all deviations from the staffing plan. The six most common reasons for deviating from the staffing plan are as follows: 1. Employee Sick Leave; 2. Family Sick Leave; 3. Employee Annual Leave; 4. Employee Emergency; 5. Mandatory Training; and 6. Adverse Weather Conditions.

HPRC Policy 3.1 entitled PREA General Requirements, page 8, section IV(A)(6) addresses 115.213(b). This policy stipulates in circumstances where the staffing plan is not complied with, HPRC will document and justify all deviations from the plan.

According to the PD interview, all instances of non-compliance with the staffing plan are documented. For example, if a case manager covers security, the same is documented on the Deviation Form. Overtime is not tracked on Deviation Forms. Time Sheets and an e-mail from the PD are forwarded to the BACS CEO and reflect the reason for overtime. The Deviation Form also reflects the reason.

Pursuant to the PAQ, the PD self reports at least once every year, the facility reviews the staffing plan to see whether adjustments are needed to:
• The staffing plan;
• Prevailing staffing patterns;
• The deployment of video monitoring systems and other monitoring technologies; or
• The allocation of facility/agency resources to commit to the staffing plan to ensure compliance with the staffing plan.

HPRC Policy 3.1 entitled PREA General Requirements, page 8, section IV(A)(7) addresses 115.213(a). This policy stipulates whenever necessary, but no less frequently than once each year, HPRC will assess, determine, and document whether adjustments are needed to:
The staffing plan established pursuant to paragraph (#5) of this section;
Prevailing staffing patterns;
Deployment of video monitoring systems and other monitoring technologies; and
The resources available to commit to ensure adequate staffing levels are met.

Pursuant to the auditor's review of the 2017 Staffing Plan, it is apparent that the requirements of this provision are met. All of the above issues have been adequately addressed.

Of note, the HPRC 2017 Staffing Plan is the first of its kind for HPRC as this review is an Initial Audit.

According to the BACS PREA Coordinator, the staffing plan for HPRC will be reviewed at least once each year and he is consulted regarding the same. Specifically, he participates in the development of the staffing plan.

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?
  x□ Yes □ No

115.215 (b)

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

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

115.215 (c)

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

    - Does the facility document all cross-gender pat-down searches of female residents?
      □ Yes □ No x NA

115.215 (d)

- Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical 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? x□ 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? x□ 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? x□ 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? x□ 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? x□ 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? x□ Yes □ No

Auditor Overall Compliance Determination

x☐ **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*)

Pursuant to the PAQ, the PD self reports the facility conducts cross-gender strip or cross-gender visual body cavity searches of residents pursuant to exigent circumstances and when performed by medical practitioners. The PD further self reports that zero cross-gender strip or cross-gender visual body cavity searches of residents were conducted during the past 12 months.

HPRC Policy 3.1 entitled PREA General Requirements, page 8, section IV(A)(8) and (9)(a)(2) addresses 115.215(a). This policy stipulates staff will not conduct cross-gender strip searches or cross-gender visual body cavity searches (meaning a search of the anal or genital opening) except in exigent circumstances or when performed by medical practitioners. Additionally, no strip searches or body cavity searches will be conducted unless prior authorization of the CEO and in his/her absence, their respective designee, is obtained. If a strip search should be deemed a necessity by the CEO or designee, typically, it will be performed only by a staff member of the same sex as the resident; however, the CEO or designee may authorize an opposite gender staff member in the case of a transgender or intersex resident.

As reflected above and pursuant to research of the Exigent Circumstances Log, no cross-gender strip searches or cross-gender body cavity searches were conducted during the past 12 months.

According to the non-medical staff involved in cross-gender strip or visual searches interviewee, no cross-gender strip or visual searches are conducted at HPRC.

Pursuant to the PAQ and memorandum dated July 12, 2017, the PD self reports female residents are not housed at HPRC. Additionally, the auditor observed no female residents housed at HPRC during the on-site audit. In view of the above and auditor observation during the facility tour, the auditor has determined that 115.215(b) is not applicable to HPRC.

Pursuant to the PAQ, the PD self reports facility policy requires that all cross-gender strip searches and cross-gender visual body cavity searches are documented. As previously indicated, female residents are not housed at HPRC and accordingly, documentation of pat searches of female residents is not applicable to HPRC.

HPRC Policy 3.1 entitled PREA General Requirements, page 8, section IV(A)(9) addresses 115.215(c). Although there are no female residents housed at HPRC, ALL cross-gender pat searches are logged in the Exigent Circumstances Log. This includes female staff pat searches of male residents. Specifically, this policy stipulates staff will document any cross-gender strip searches and cross-gender visual body cavity searches, and documents all cross-gender pat-down searches in the exigent circumstances log. This policy (regarding documentation of all cross-gender pat searches, inclusive of such searches of male residents) clearly exceeds the provision language.

Pursuant to the PAQ, the PD self reports the facility has implemented policies and procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical 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 (this includes viewing via video camera). The PD further self reports policies and procedures require staff of the opposite gender to announce their presence when entering a resident housing unit.

HPRC Policy 3.1 entitled PREA General Requirements, pages 8 and 9, section IV(A)(10, 11) addresses 115.215(d). This policy stipulates HPRC enables residents to shower, perform bodily functions, and change clothing without non-medical 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. Opposite gender staff will announce their presence before entering a hallway and prior to entering any living area, bathroom, or shower room. Signage stating HPRC is staffed with female and male staff 24 hours per day will be posted in conspicuous areas for resident awareness.

Ten of the twelve random staff interviewees asserted female staff do announce their presence on wings prior to walking down the same. The remaining two staff were male staff and responded that they (personally) did not announce themselves. Eight of the twelve random staff asserted female staff knock on room doors, announce themselves, wait, and then enter resident rooms. The same procedure, or a variation thereof, is employed prior to staff entering bathrooms. It is noted that random staff interviewees were comprised of an equal number of both male and female staff. Of note, the four random staff who did not comment regarding the procedure employed by female staff, were males.

All 12 random staff interviewees reported residents are able to dress, shower, and toilet without being viewed by staff of the opposite gender.

During the facility tour, the auditor did observe female staff announcing themselves prior to entering housing wings. Additionally, cameras are positioned in such a manner they do not capture the interior of rooms or the bathrooms. Furthermore, the auditor observed camera footage in the bubble and found no evidence of staff being able to observe room and bathroom interiors.

Seventeen of the nineteen random resident interviewees assert opposite gender staff (females)announce their presence when entering housing areas. One of the 19 interviewees advised he didn't know as he wears his headset most of the time. Another random resident interviewee asserted females on the evening shift don't always announce their gender. Interestingly, no other resident interviewees asserted any such claim.

All 19 of the random resident interviewees assert opposite gender (female) staff knock on the room door, announce gender or task, wait, and then enter their room, or some variation thereof. Interviewees also assert female staff employ the same practice when entering bathrooms.

In response to the question as to whether the resident or any other residents were ever naked in full view of opposite gender (female) staff whenever they showered, toileted, or changed clothing, all 19 of the random resident interviewees responded in the negative.

Essentially, random staff interviewees corroborated random staff interviewees with respect to this provision. Accordingly, the auditor finds substantial compliance with this provision.

Pursuant to the PAQ, the PD self reports the facility has a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. The PD further self reports such searches have not occurred at HPRC during the past 12 months.

HPRC Policy 3.1 entitled PREA General Requirements, page 8, section IV(A)(9)(a)(3) addresses 115.215(e). This policy stipulates the facility shall not search or physically examine any resident, including transgender and intersex residents for the sole purpose of determining the resident's genital status. If staff cannot determine the biological sex of a resident, the staff shall ask medical personnel for resident verification of the sex of the genitalia. Medical staff must conduct this inquiry in private and in a professional manner to preserve confidentiality in order to avoid subjecting the resident to abuse or ridicule.

All 12 of the random staff interviewees advise they are aware of the policy prohibiting staff from searching or physically examining a transgender or intersex resident for the purpose of determining that resident's genital status. As previously referenced, transgender/intersex resident(s) were not housed at HPRC at the time of the on-site audit. Accordingly, the respective interview questions were not asked.

Pursuant to the PAQ, the PD self reported that 100% of all security staff received training on conducting cross-gender pat-down searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs.

HPRC Policy 3.1 entitled PREA General Requirements, page 8, section IV(A)(9)(a)(1) and page 9, section IV(A)(12) addresses 115.215(f). This policy stipulates security staff will be trained on cross-gender pat searches and will only perform these searches under emergency/exigent circumstances. Additionally, HPRC will train security staff in how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs in the event such search is deemed necessary.

The auditor reviewed training documentation as described in the narrative for 115.231(a). Files for three staff who completed PREA Orientation training were included in the 26 files reviewed. The auditor has also reviewed another Orientation file and finds that Cross-Gender and Transgender Pat Search training was provided to all staff represented, inclusive of the 23 In-Service PREA training participants.

All of the 12 random staff interviewees assert they received training on how to conduct cross-gender pat down searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs. Training has been provided during Orientation and Annual PREA Refresher Training via Power Point presentation and/or video. Some staff reported the video is available for review on-line.

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? x□ 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? x□ 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? x□ 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? x□ 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? x□ 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.) x□ Yes □ No

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

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the PD self reported the agency has established procedures to provide disabled residents 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.

HPRC Policy 3.3 entitled Intake/Screening, pages 2 and 3, section II(A)(2) addresses 115.216(a). This policy stipulates HPRC shall take appropriate steps to ensure that Residents with disabilities (including, for example, Residents who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities), have an equal opportunity to participate in or benefit from all aspects of HPRC's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Such steps shall include, when necessary to ensure effective communication with Residents who are deaf or hard of hearing, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. In addition, HPRC shall ensure that written materials are provided in formats or through methods that ensure effective communication with Residents with disabilities, including Residents who have intellectual disabilities, limited reading skills, or who are blind or have low vision. By taking no actions to assist those with disabilities, would result in a violation of title II of the Americans with Disabilities Act, 28 CFR 35.164.

HPRC Policy 3.3 entitled Intake/Screening, page 2, section II(A)(1)(b) also addresses 115.216(a). This policy stipulates HPRC will provide Resident education in formats accessible to all Residents, which will include written material and viewing the video "What You Need to Know", including those who are limited English proficient by providing interpreters who speak the same language, deaf, visually impaired, or otherwise disabled as well as Residents who have limited reading skills by reading the information to them.

As part of the PAQ submission, a copy of the enlarged print version of the HPRC PREA Handbook was provided. This version of the Handbook is available for residents who have low vision. Additionally, the PD self reported in a memorandum dated July 7, 2012, that he has an education background with special education and HPRC would use the mental health counselor if the need arose for those with learning disabilities or residents that are low functioning.

It is also noted the PREA video "What You Need to Know" is closed captioned. Thus, residents who are deaf or hard of hearing also have access to education by virtue of this feature, as well as, reading the HPRC PREA Handbook.

In addition to the above, Montana Department of Corrections Probation and Parole Division Operational Procedure PPD 4.1.100, page 2, section III(A) and (B) addresses the requirements for resident participation in the HPRC program, as well as, other pre-release center programs. This policy stipulates (in the section entitled Requirements for Pre-Release Centers) that offenders will be physically and mentally capable of work, education, or vocational training. If they are unable to work due to a disability, i.e. a verified physical or mental handicap, and/or they are eligible for Veterans Administration Benefits, SSI, or Vocational Rehabilitation Services, they must have a realistic plan to subsidize their stay at the PPD facility. In the section entitled Requirements for all Facilities, the policy stipulates that if an offender has a medical or psychological condition, facility staff and the facility's screening coordinator will assess the offender to determine if his/her needs can be met in a community-based setting.

In response to whether the agency has established procedures to provide residents with disabilities and residents who are limited English proficient 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, the CEO responded in the affirmative. Specifically, she asserted that closed captioned videos, large print PREA Handbooks, specialty staff for cognitively impaired at both HPRC and ETC, staff read to blind residents, and there is a PREA audio (not updated) available to HPRC residents.

Two residents with disabilities advise the facility provides information about sexual abuse and sexual harassment that they are able to understand. Specifically, they received a PREA Handbook and participated in Orientation. As previously stated, there were no Limited English Proficient (LEP) residents housed at HPRC during the on-site audit.

Pursuant to the PAQ, the PD self reported the agency has established procedures to provide residents with limited English proficiency 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.

HPRC Policy 3.3 entitled Intake/Screening, page 3, section II(A)(3) addresses 115.216(b). This policy stipulates HPRC shall take reasonable steps to ensure meaningful access to all efforts to prevent, detect, and respond to sexual abuse and sexual harassment to Residents who are limited English proficient, including interpreters, where a list of interpreters can be provided from the Program Administrator, who are capable of interpreting effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary.

HPRC contracts with CTS Language Link to provide interpretation services for residents who are limited English proficient. A copy of the contract was included with PAQ materials. The Language Link contract encompasses in excess of 240 languages.

As noted in the narrative for 115.216(a), no LEP residents were housed at HPRC during the on-site audit.

Pursuant to the PAQ, the PD self reports agency policy prohibits use of 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-responder duties under 115.264, or the investigation of the resident's allegations. The PD further self reports the facility documents the limited circumstances in individual cases where resident interpreters, readers, or other types of resident assistants are used. Reportedly, there were zero instances in the past 12 months where resident interpreters, readers, or other types of resident assistants have been used and it was not the case that an extended delay in obtaining another interpreter could compromise the resident's safety, the performance of first-responder duties, or the investigation of the resident's allegations.

HPRC Policy 3.3 entitled Intake/Screening, page 3, section II(A)(4) addresses 115.216(c). This policy stipulates HPRC will not rely 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, or the investigation of the Residents allegations. Limited circumstances will be promptly documented, if need occur.

While policy allows for the use of resident translators/interpreters in accordance with the exceptions noted in this provision, all 12 random staff interviewees assert the agency does not allow the use of resident interpreters, resident readers, or other types of resident assistants to assist disabled residents or LEP residents when making an allegation of sexual abuse or sexual harassment. All 12 interviewees also assert there are no exceptions to the above. Finally, all 12 interviewees assert that to the best of their knowledge, resident interpreters, resident readers, or other types of resident assistants have not been used in relation to allegations of sexual abuse or sexual harassment during the past 12 months.

One of the 12 interviewees advised they are trained in this regard. Pursuant to conversation with the BACS PREA Coordinator, the auditor learned training does encompass the language of 115.216(c). However, staff may be discouraged from using resident translators, etc. in this scenario. The auditor does not find 115.216(c) to be deficient as HPRC does not loosen the intent of the provision. It is however, strongly recommended that this issue be addressed again with staff to ensure they understand the options.

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)? x□ 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? x□ 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? x□ 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)? x□ 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? x□ 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? x□ Yes □ No

115.217 (b)

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

115.217 (c)

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

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

115.217 (g)

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

115.217 (h)

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the PD self reports agency policy prohibits hiring or promoting anyone who may have contact with residents and prohibits enlisting the 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);
• 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; or
• Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section.

BACS Personnel Manual 2017, page 85, section entitled Recruitment addresses 115.217(a). This policy stipulates applicants who have engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution; have 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; or have been civilly or administratively adjudicated to have engaged in the activity described above shall be considered unsuitable for employment with Boyd Andrew Community Services.

In addition to the above, BACS Policy 1.3.5.12 entitled PREA Policy, page 7, section 217(a) addresses 115.217(a). This policy stipulates BACS shall not hire or promote anyone who may have contact with residents, and shall not enlist the services of any contractor who may have contact with residents, who— (1) 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); (2) 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; or (3) Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section.

The auditor reviewed interview questions for all positions falling under the umbrella of BACS facilities management. All interview question sets contain the questions set forth in 115.217(a). These same questions, as well as, the afore-mentioned questions germane to 115.217(a) are asked during promotion interviews, according to the PREA Coordinator.

The auditor was provided interview notes addressing these three questions for one of three interviewees. There is no evidence reflecting these questions are asked on the employment application.

Finally, the auditor inquired regarding one individual who was promoted during the past year and was advised he/she was appointed. There was no application phase or promotion interview.

In regard to contractors, the auditor has not been provided any evidence substantiating compliance with 115.217(a).

In view of the above, the auditor finds HPRC is non-compliant with 115.217(a). Specifically, there is a lack of evidence to prove substantial compliance with the provision.

In an effort to certify compliance with this provision, it is recommended the BACS PREA Coordinator will provide completed copies of prior employment reference checks bearing a response to the three questions articulated in this provision for both applicants and contractors. The document will reflect the date of the response, the responding employer's name and signature, the applicant's name, and the position he/she seeks. If the reference check is accomplished via telephone, the hiring manager will ensure the same information is reflected on the document. It is recommended the BACS PREA Coordinator develop a form which adequately captures the above, as well as, the specific statements of the former employer in response to the questions.

As previously mentioned, interview forms do not reflect a question regarding the requisite three questions as articulated in 115.217(a). This form will need to be revised to include the information articulated in the preceding paragraph. The BACS PREA Coordinator will provide completed copies of interview notes to the auditor relative to new hires, promotion applicants, as well as, any contractor(s).

HPRC will have to capture responses to the three questions during the promotion process, as previously described. A copy of the appointment letter (or equivalent thereof) or promotion letter will assist the auditor in assessing whether the promotion applicant's responses to the three questions were considered in the hiring/promotion decision. Accordingly, this document must also be included in the packet forwarded to the auditor.

Given the complexity of the above, training of hiring managers regarding these procedures will be essential. Institutionalization and inclusion into the facility culture will be accomplished pursuant to training, repetition, and monitoring. Accordingly, the BACS PREA Coordinator will also forward copies of training sheets regarding this matter to the auditor.

This process must be completed on or before April 24, 2018 to ensure the auditor can conclude review and assessment of corrective action prior to corrective action period closure. This provision can be closed prior to the afore-mentioned date based on the auditor's assessment.

12/18/2017 Update:

The auditor has been provided with copies of the revised interview notes and previous employer reference checks forms. Both documents have been revised to include the three questions as identified above, as well as, a question regarding sexual harassment. The forms meet the expectations of the previously identified corrective action.

1/11/2018 Update:

The auditor has been provided evidence reflecting the PREA Manager at HPRC (also the hiring manager at HPRC) has received training regarding all forms/implementation of the same related to findings referenced in this standard. The training was provided on January 2, 2018.

1/22/2018 Update:

The auditor has been provided with completed documents related to two recent hires at HPRC. Verbiage is present in the body of the Application, addressing the questions articulated in 115.217(a). The applicant checks the correct boxes and signs the document. Similarly, the relevant questions, inclusive of a question regarding sexual harassment, are reflected in the employer Reference Check Form. Relevant boxes are checked by the PD in both cases as he facilitated telephone interviews. Similarly, the completed Applicant Interview Form reflects responses to the questions identified in the preceding sentence.

It is noted one of these selectees was previously selected as an intern and was recently promoted to a security position. A BACS form entitled, PREA Acknowledgment for Promotions, Appointments and Contractors was included in the evidence. The same reflects the three questions reflected in 115.217(a), as well as, a question regarding sexual harassment and the se-

lectee's response to the same (applicable boxes are checked). The selectee's signature is affixed on the signature line, attesting to his/her response.

According to the BACS PREA Coordinator, no contractors have been hired at HPRC since the dates of the on-site audit.

The auditor finds HPRC to be substantially compliant with 115.217(a) and (b).

Pursuant to the PAQ, the PD self reports agency policy requires the consideration of any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.

BACS Policy 1.3.5.12 entitled PREA Policy, page 7, section 115.117(b) addresses 115.217(b). This policy stipulates BACS shall consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.

According to the Human Resources staff interviewee, the facility considers prior incidents of sexual harassment when determining whether to hire or promote anyone, or to enlist the services of any contractor who may have contact with residents. The interviewee asserts that a sexual harassment question is included in the reference check (vetting) questionnaire.

According to the BACS PREA Coordinator and evidence presented, there is only one file of four wherein evidence reflects that previous institutional employers were questioned regarding incidents of sexual harassment of residents/inmates/etc. during the applicant's previous employment. Specifically, while applicants were reference checked, records/notes were either not maintained or were subsequently destroyed.

In addition to the above, there is no evidence reflecting that applicants/interviewees were questioned about the existence of sexual harassment of confined individuals during their previous work history. The BACS PREA Coordinator reports that all interview question sheets (used during employment and promotion interviews) have been updated to include this question.

It is also noted the auditor has not been provided any evidence regarding this matter as applied to contractors.

In view of the above, the auditor finds HPRC to be non-compliant with this provision. In an effort to certify compliance with this provision, the BACS PREA Coordinator will provide completed copies of prior institutional employment reference checks bearing a response to the sexual harassment question for both applicants and contractors. The document will reflect the date of the response, the responding employer's name and signature, the applicant's name, and the position he/she seeks. If the reference check is accomplished via telephone, the hiring manager will ensure the same information is reflected on the document. It is recommended that the BACS PREA Coordina-

tor develop a form which adequately captures the above, as well as, the specific statements of the former employer in response to the questions.

As previously mentioned, interview forms have been revised to add a question regarding sexual harassment of residents, inmates, etc. during the applicant's work history. This form will need to be revised to include the information articulated in the preceding paragraph. The BACS PREA Coordinator will provide completed copies of interview notes to the auditor relative to new hires, promotion applicants, as well as, any contractor(s).

A copy of the appointment letter (or equivalent thereof) or promotion letter will assist the auditor in assessing whether the prevalence of sexual harassment was considered in the hiring/promotion decision. Accordingly, this document must also be included in the packet forwarded to the auditor.

Given the complexity of the above, training of hiring managers regarding these procedures will be essential. Institutionalization and inclusion into the facility culture will be accomplished pursuant to training, repetition, and monitoring. Accordingly, the BACS PREA Coordinator will also forward copies of training sheets regarding this matter to the auditor.

This process must be completed on or before April 24, 2018 to ensure the auditor can conclude review and assessment of corrective action prior to corrective action period closure. This provision can be closed prior to the afore-mentioned date based on the auditor's assessment.

12/18/2017 Update:

The auditor has been provided with copies of the revised interview notes and previous employer reference checks forms. Both documents have been revised to include the three questions as identified above, as well as, a question regarding sexual harassment. The forms meet the expectations of the previously identified corrective action.

The auditor has reviewed one previous employer reference check set and interview notes applicable to an “intern applicant”. The revised reference check form was utilized with respect to previous employers, although none of the same were considered institutional employers. Documentation substantiates compliance with this provision and compliance with the corrective action previously cited.

According to the BACS PREA Coordinator, no contractors have been selected at HPRC since the dates of the on-site audit.

1/22/2018 Update:

Provision of the training corrective action is addressed above regarding provision 115.217(a).

The auditor finds HPRC to be substantially compliant with 115.217(b).

Pursuant to the PAQ, the PD self reports agency policy requires that before it hires any new employees who may have contact with residents, it (a) conducts criminal background record checks, and (b) consistent with federal, state, and local law, makes 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. The PD further self reports there were 16 staff hired during the past 12 months (100%) who may have contact with residents have had criminal background record checks.

BACS Personnel Manual 2017, page 84, section entitled Recruitment addresses 115.217(c). This policy stipulates applicants shall be required to consent to a criminal background check as related to CFR 115.217. Failure to provide consent or the existence of a criminal background deemed non-compliant with current federal code will result in disqualification from consideration for employment.

BACS Policy 1.3.5.12 entitled PREA Policy, page 8, section 115.217(c) addresses 115.217(c). This policy stipulates before hiring new employees who may have contact with residents, BACS shall: (1) Perform a criminal background records check; and (2) 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.

Four of the four criminal background records checks reviewed were completed prior to the hire date of the employees. None of these documents reflected any offenses as reflected in 115.217(a).

In regard to reference check documents with previous institution employers regarding these same four staff, the auditor received one such document. While the BACS PREA Coordinator asserts multiple telephonic requests were made regarding another of these employees, calls were reportedly not returned. Additional contact with individuals at the location resulted in irrelevant information. No evidence substantiating the calls forwarded to the employer was provided to the auditor.

In view of the above, the auditor finds HPRC to be non-compliant with 115.217(c). Much like the corrective action articulated in the narrative for 115.217(b), the BACS PREA Coordinator will forward to the auditor copies of the documents forwarded to previous institutional employers regarding substantiated allegations of sexual abuse or any resignation pending investigation of an allegation of sexual abuse, as well as the previous employer's response, for a period not to exceed April 24, 2018. All requirements as articulated in the narrative for 115.217(a) and (b) likewise apply to this provision.

12/18/2017 Update:

The auditor has been provided with copies of the revised interview notes and previous employer reference check forms. Both documents have been revised to include the three questions as identified above, as well as, a question regarding sexual harassment. The forms meet the expectations of the previously identified corrective action.

The auditor has reviewed one previous employer reference check set and interview notes applicable to an "intern applicant". The revised reference check form was utilized with respect to previous employers, although none of the same were considered institutional employers. Documentation substantiates compliance with this provision and compliance with the corrective action previously cited.

1/22/2018 Update:

See the corrective action noted for 115.217(a) above.

The auditor finds HPRC to be substantially compliant with 115.217(c).

Pursuant to the PAQ, the PD self reports agency policy requires that a criminal background record check be completed before enlisting the services of any contractor who may have contact with residents. The PD further self reports that criminal background checks were completed regarding two contract providers providers who may have contact with residents, during the past 12 months. This represents 100% of contract staff who might have contact with residents.

BACS Policy 1.3.5.12 entitled PREA Policy, page 8, section 115.217(d) addresses 115.217(d). This policy stipulates BACS shall also perform a criminal background records check before enlisting the services of any contractor who may have contact with residents.

According to the Human Resources interviewee, the facility performs criminal record background checks or considers pertinent civil or administrative adjudications for all newly hired employees who may have contact with residents, and all employees, who may have contact with residents who are considered for promotions. Additionally, the same practice is used for any contractor who may have contact with residents, as well.

A spread sheet reflecting date of hire is used to facilitate this process. The spreadsheet is checked every couple months to ensure a 5-year re-investigation is not missed.

The auditor reviewed a criminal background records check regarding one individual who was hired as a contractor during the past 12 months. The criminal background records check was completed on February 7, 2017 and he/she was appointed as a contractor on March 29, 2017. This individual has also worked at HPRC as a part-time security specialist. The criminal record background check was clear in terms of offense(s) committed in Montana.

It is noted that the Montana Public Criminal History Record is used as the assessment vehicle to identify

criminal background history as applicable to "New Hires", staff promotions, contractors, and volunteers. This procedure encompasses only those arrests/convictions occurring within the State of Montana. Given the transient society in which we work, this process leaves the possibility of hiring employees who have been involved in the offenses articulated in provision 115.217(a) in a State other than Montana. Accordingly, offender and staff sexual safety at HPRC could be adversely impacted by this condition.

Accordingly, in an effort to facilitate the best hiring/promotion decision-making in promotion of sexual safety as previously articulated, it is recommended that a different background check procedure be implemented. As an example, utilization of NCIC would provide a better snapshot from a national perspective. Given the fact that BACS is a private corporation, there may be some difficulties in terms of certifying staff to facilitate the NCIC.

As the result of personal experience, accomplishment of this critical task may be more appropriately handled by the State of Montana. Personal experience has revealed that staff from State entities are generally more likely to be granted such access following a training and certification process. This is recommended as a PREA "Best Practice" in an attempt to facilitate sexual safety at HPRC.

In view of the above, the auditor finds substantial compliance with 115.217(d).

Pursuant to the PAQ, the PD self reports agency policy requires that either criminal background record checks be conducted at least every five years for current employees and contractors who may have contact with residents or that a system is in place for otherwise capturing such information for current employees.

BACS Policy 1.3.5.12 entitled PREA Policy, page 8, section 115.217(e) addresses 115.217(e). This policy stipulates BACS shall 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.

According to the Human Resources interviewee, Human Resources staff run criminal records background checks with the Montana Department of Justice (MDOJ) check. Criminal record background checks are completed every five years. The procedure for accomplishing the same is explained in the narrative for 115.217(d).

The workforce at HPRC is comprised of 25 staff who have contact with residents. The majority of staff have less than three years of service and accordingly, reviewing files for a representative number of staff wherein five-year re-investigations have been conducted, is difficult, at best.

In view of the above, the auditor reviewed files for three of the longest tenured employees at HPRC. Their Entry On Duty (EOD) dates were 2006, 2007, and 2009. While some five-year re-investigations were missing, all had a five-year re-investigations completed during 2016.

Clearly, as reflected in this narrative and the narrative for 115.217(d), there is a protocol in place to track and ensure five-year re-investigations are completed. Accordingly, the auditor finds that for purposes of this Initial PREA Audit, the intent of the standard is met. There is evidence suggesting five-year re-investigations are being implemented.

BACS Policy 1.3.5.12 entitled PREA Policy, page 8, section 115.217(f) addresses 115.217(f). This policy stipulates BACS shall also 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 and in any interviews or written self-evaluations conducted as part of reviews of current employees. BACS shall also impose upon employees a continuing affirmative duty to disclose any such misconduct.

According to the Human Resources interviewee, applicants and employees who have contact with residents are asked about previous misconduct described in 115.217(a) in written applications for hiring or promotions, and in any interviews or written self-evaluations conducted as part of reviews of current employees. The interviewee was uncertain as to the duration of the practice. The questions were asked in a recent interview conducted at HPRC.

In addition to the above, the interviewee asserts the facility imposes upon employees a continuing affirmative duty to disclose any such previous misconduct as described in the narrative for 115.217(a).

The auditor has not been provided any substantiating evidence with respect to application questions regarding the three issues articulated in 115.217(a). Additionally, as previously indicated, the one employee promoted during the past 12 months was appointed and therefore did not participate in an interview. Accordingly, no substantiating evidence has been provided regarding the requirements of this provision being implemented during a promotion interview. Finally, the auditor has not been provided any substantiating evidence proving that staff are asked the three questions articulated in 115.217(a) during written self-evaluations conducted as part of performance reviews.

In view of the above, the auditor finds HPRC to be non-compliant with 115.217(f). As corrective action, it is recommended the BACS PREA Coordinator develop a form reflecting the three questions articulated in 115.217(a). The form will reflect the prospective employee's, promotion interviewee's, and the employee participating in the performance evaluation process, printed name/ signature, and the date of execution. Additionally, a signature line should be available for the supervisory witness. This form can be utilized during the interview and performance appraisal process.

In addition to the above, the employment application must be changed to reflect the three questions articulated in 115.217(a) and whether the applicant has committed them or received some form of judgment for such actions. The revised application must be used henceforth.

Corrective action regarding employment/promotion interviews is discussed in the narrative for 115.217(a).

Upon completion of these tasks, the BACS PREA Coordinator and/or Business Manager must provide training to hiring managers regarding the performance evaluation change, and all staff regarding the employment application/interview changes. Copies of the training records for the issues described above, will be forwarded to the auditor for review. Additionally, copies of completed employment and promotion (if applicable) applications and completed copies of the proposed new form to be used during interviews and performance review discussions, etc., will be forwarded to the auditor for review.

This process must be completed on or before April 24, 2018 to ensure the auditor can conclude review and assessment of corrective action prior to corrective action period closure. This provision can be closed prior to the afore-mentioned date based on the auditor's assessment.

12/18/2017 Update:

The auditor has been provided copies of a revised Performance Evaluation Form which bears the information [inclusive of the three questions reflected in 115.217(a)] referenced in the above corrective action. Additionally, verbiage is included, placing staff on notice of their continuing affirmative obligation to report the information articulated in 115.217(a).

02/15/2018 Update:

The auditor has been provided completed copies of six-month evaluations, employee self-evaluations of performance, and annual performance evaluations for two employees wherein the requisite questions are asked, as well as, notice regarding the staff member's continuing affirmative obligation to report the information articulated in 115.217(a). The documents are properly signed, acknowledging the information contained therein.

In view of the above, the auditor finds HPRC to be compliant with 115.217(f).

Pursuant to the PAQ, the PD self reports agency policy states that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

BACS Policy 1.3.5.12 entitled PREA Policy, page 8, section 115.217(g) addresses 115.217(g). This policy stipulates material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

BACS Policy 1.3.5.12 entitled PREA Policy, page 8, section 115.217(h) addresses 115.217(h). This policy stipulates unless prohibited by law, BACS shall 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.

According to the Human Resources interviewee, she would provide information on any substantiated allegations of sexual abuse or sexual harassment involving former employee(s) whenever a prospective employer (for the former employee) requests such information.

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 x□ 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 x□ NA

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the PD self reported the facility has not acquired a new facility or made a substantial expansion or modification to existing facilities since August 20, 2012. Accordingly, the auditor has determined provision 115.218(a) is not applicable to HPRC.

Pursuant to the PAQ, the PD self reported the facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012. The auditor has determined there is substantial compliance with this provision.

The above was substantiated by the PD during his interview.

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.) x□ 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.) x□ 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.) x□ Yes □ No □ NA

115.221 (c)

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

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

- Has the agency documented its efforts to provide SAFEs or SANEs? x□ Yes □ No

115.221 (d)

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

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

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

115.221 (f)

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

115.221 (g)

- Auditor is not required to audit this provision.

115.221 (h)

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the PD self reports the facility is responsible for conducting administrative sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). The Helena Police Department (HPD) facilitates criminal investigations in response to sexual abuse or sexual misconduct. The PD further self reports when conducting a sexual abuse investigation, the agency investigators follow a uniform evidence protocol.

HPRC Policy 3.4 entitled Reporting, page 8, section II(E)(1) addresses 115.221(a). This policy stipulates HPRC is responsible for investigating all allegations of administrative sexual abuse and sexual harassment and HPRC follows a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions.

Seven of the 12 random staff interviewees responded appropriately to all four requirements of the uniform evidence protocol, ensuring maximization of the potential for obtaining usable physical evidence. The five remaining interviewees addressed at least three of the four requirements. Two interviewees did not address separation of the victim and perpetrator and three interviewees asserted both victim and perpetrator would be precluded from destroying physical evidence.
The auditor finds there is substantial compliance with 115.221(a). However, it is recommended staff be reminded of all four requirements of evidence preservation as applicable to first responders.

Of the 12 random staff interviewees, 11 staff accurately identified the administrative and criminal PREA investigators at HPRC.

Pursuant to a memorandum dated August 7, 2017 from the PD, juvenile offenders are not housed at HPRC. It is noted the facility PREA investigators are trained pursuant to the NIC investigative protocol.

The auditor has reviewed the evidence protocol established in HPRC Policy 3.11 entitled Coordinated Response/Staff First Response Duties and has determined there is sufficient technical detail to aid responders in obtaining usable physical evidence. Additional detail regarding the protocol is provided in the narrative for 115.264.

Pursuant to the PAQ, the PD self reports the facility offers to all residents who experience sexual abuse access to forensic medical examinations at a community hospital. The PD further self reports forensic medical examinations are offered without financial cost to the victim. Where possible, examinations are conducted by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs). When SANEs or SAFEs are not available, a qualified medical practitioner performs forensic medical examinations. Finally, the PD self reports the facility would document efforts to provide SANEs or SAFEs.

The PD reports that zero forensic medical examinations were conducted during the past 12 months.

HPRC Policy 3.4 entitled Reporting, pages 8 and 9, section II(E)(3) addresses 115.221(c). This policy stipulates forensic examinations will be conducted at no cost to the resident. Every attempt will be made to have the exam conducted by a Sexual Assault Forensic Examiner (SAFE) or a Sexual Assault Nurse Examiner (SANE) through St. Peter's Hospital in Helena, who has provided service documentation for HPRC and/or BACS. If a SAFE or SANE is not available, the examinations will be performed by another qualified medical practitioner. Staff will document their efforts to provide SAFE or SANE professionals in the resident's progress notes and in all incident reports. HPRC shall document its efforts to provide SAFEs or SANEs.

The SANE interviewee was a SANE-trained nurse at St. Peter's Hospital. He/she is SANE-trained, not SANE-certified. The SANE training is a State funded national standards training provided once per year.

SANE-trained nurses work in conjunction with an Emergency Room (ER) Physician. The physician is present during part of the examination however, he/she is not present during the evidence collection process. If a SANE-trained nurse is not available for some reason, it is expected that ER Nurses be able to facilitate a kit.

The interviewee is one of seven SANE-trained nurses at St. Peter's Hospital.

The interviewee, as well as, six other SANE-trained nurses are responsible for conducting all forensic medical examinations for Helena citizens, as well as, HPRC residents. According to the interviewee, there will always be a SANE-trained nurse available, even if the interviewee is called in.

Pursuant to the PAQ, the PD self reports the facility attempts to make a victim advocate from a rape crisis center available to the victim, either in person or by other means. The PD further self reports these efforts are documented. If and when a rape crisis center is not available to provide victim advocate services, the facility provides a qualified staff member from a community-based organization or a qualified agency staff member.

HPRC Policy 3.4 entitled Reporting, page 9, section II(E)(4) addresses 115.221(d). This policy stipulates HPRC shall attempt to make available to the victim a victim advocate from a rape crisis center/Safe Space or Friendship Center. If a rape crisis center/Safe Space/Friendship Center is not available to provide victim advocate services, HPRC shall make available to provide these services a qualified staff member from a community-based organization or a qualified staff member. HPRC shall document efforts to secure services from rape crisis centers. For the purpose of this standard, a rape crisis center refers to an entity that provides intervention and related assistance, such as the services specified in 42 U.S.C. 14043g(b)(2)(C), to victims of sexual assault of all ages. HPRC may utilize a rape crisis center that is part of a governmental unit as long as the facility is not part of the criminal justice system (such as a law enforcement agency) and offers a comparable level of confidentiality as a non-governmental entity that provides similar victim services.

The auditor has reviewed MOUs between the HPRC PD and leadership at both The Friendship Center and Safe Space (dated February 28, 2017). Duties and expectations for both HPRC staff and The Friendship Center/Safe Space are clearly articulated in each MOU. Confidentiality is also addressed in each MOU.

In addition to the above, the auditor reviewed documentation reflecting completion of the PREA Resource Center course entitled PREA and Victim Services: A Trauma-Informed Approach, by an HPRC staff member. This is a Victim Advocate (VA) course for facility staff. Accordingly, HPRC does have the availability of a trained facility VA.

According to the BACS PREA Coordinator, HPRC makes available to residents VAs (pursuant to Safe Space and Friendship Center. Additionally, one PREA Resource Center trained VA is utilized at HPRC. Safe Space VAs have been trained regarding PREA requirements by a PREA Coordinator from another company. MOUs have been developed between Safe Space and Friendship Center.

Pursuant to the PAQ, the PD self reports if requested by the victim, a victim advocate, qualified agency staff member, or qualified community-based organization staff member accompanies and supports the victim through the forensic medical examination process and investigatory interviews and provides emotional support, crisis intervention, information, and referrals.

HPRC Policy 3.4 entitled Reporting, page 9, section II(E)(5) addresses 115.221(e). This policy stipulates as requested by the victim, the victim advocate, qualified staff member, or qualified community-based organization staff member shall accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals.

According to the BACS PREA Coordinator, if requested by the victim, a victim advocate, qualified agency staff member, or qualified community-based organization staff member accompanies and provides emotional support, crisis intervention, information, and referrals during the forensic medical examination process and investigatory interviews.

Pursuant to the PAQ, the PD self reports as the agency is not responsible for investigating criminal allegations of sexual abuse and relies on another agency to conduct these investigations, the HPRC PD has requested that the responsible agency follow the requirements of paragraphs §115.221 (a) through (e) of these standards.

HPRC Policy 3.4 entitled Reporting, page 9, section II(E)(6) and (7) addresses 115.221(f). This policy stipulates to the extent HPRC itself is not responsible for investigating criminal allegations of sexual abuse, HPRC shall request that the investigating agency/Helena Police Department follow the requirements of paragraphs (a) through (e) of this section.

The lead agency/Helena Police Department shall follow PREA standards according to investigations. HPRC holds an MOU with HPD for investigation of all sexual abuse and sexual assault incidents.

The auditor reviewed an MOU dated February 23, 2017 between the PD and HPD Chief of Police regarding the conduct of criminal investigations of sexual abuse at HPRC. Duties and responsibilities of both HPRC PREA Investigator(s) and HPD investigators are clearly scripted in the MOU. The elements of this standard are reflected in the MOU.

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? x□ Yes □ No
- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment? x□ 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? x□ 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? x□ Yes □ No
- Does the agency document all such referrals? x□ Yes □ No

115.222 (c)

- If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? [N/A if the agency/facility is responsible for conducting criminal investigations. See 115.221(a).] □ Yes x□ 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*)

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

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

Pursuant to the PAQ, the PD self reported the agency ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment (including resident-on-resident sexual abuse and staff sexual misconduct). The PD further self reported one allegation of sexual

abuse or sexual harassment was received during the past 12 months. This allegation resulted in an administrative investigation and no criminal investigations were reported during the past 12 months. HPRC Policy 3.4 entitled Reporting, page 2, section II(A)(11) addresses 115.222(a). This policy stipulates HPRC will ensure that an administrative and/or criminal investigation is completed for all allegations of abuse, neglect, sexual abuse or sexual harassment.

The auditor reviewed the afore-mentioned administrative investigation and finds the same to be complete and in compliance with 115.221, 115.222, and 115.271.

When questioned as to whether the agency ensures an administrative or criminal investigation is completed for all allegations of sexual abuse or sexual harassment, the CEO responded in the affirmative. The CEO further expounded administrative investigation(s) are conducted in sexual harassment scenarios. Witnesses are interviewed, cameras are reviewed, any relevant technology is reviewed, and the perpetrator is removed from the facility. Sexual abuse cases are referred to HPD or the ETC law enforcement point of contact. Separate victim and perpetrator immediately.

Pursuant to the PAQ, the PD self reported the agency has a policy that requires allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, including the agency if it conducts its own investigations, unless the allegation does not involve potentially criminal behavior. The PD further self reports agency policy regarding the referral of allegations of sexual abuse or sexual harassment for criminal investigation is published on the agency website or made publicly available via other means. According to the PD, the agency documents all referrals of allegations of sexual abuse or sexual harassment for criminal investigation.

HPRC Policy 3.4 entitled Reporting, page 3, section II(A)(12) addresses 115.222(b). This policy stipulates the Helena Police Department will be considered the lead agency for allegations of sexual assault investigations and will determine if criminal charges are warranted. A mutual agreement exists between HPRC and the Helena Police Department for investigations related to sexual assault and sexual abuse. The existing MOU can be found on the BACS website at www.boydandrew.com. The Montana Department of Corrections shall be kept informed of proceedings conducted by the Helena Police Department investigation team.

The auditor reviewed the MOU between HPRC and the HPD and found the same to be commensurate with 115.222(c). Specifically, both agency and HPD responsibilities are articulated in the document.

The MOU is posted on the BACS website.

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? x□ 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? x□ 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 x□ 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? x□ Yes □ No
- Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in juvenile facilities? x□ Yes □ No
- Does the agency train all employees who may have contact with residents on: The common reactions of juvenile victims of sexual abuse and sexual harassment? x□ 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? x□ Yes □ No
- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? x□ 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? x□ 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? x□ Yes □ No

115.231 (b)

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

115.231 (c)

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

115.231 (d)

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

Auditor Overall Compliance Determination

x☐ **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*)

Pursuant to the PAQ, the PD self reports the agency trains all employees who may have contact with residents on the following matters:

(1) Its zero-tolerance policy for sexual abuse and sexual harassment;
(2) How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures;
(3) Residents' rights to be free from sexual abuse and sexual harassment;
(4) The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment;
(5) The dynamics of sexual abuse and sexual harassment in confinement;
(6) The common reactions of sexual abuse and sexual harassment victims;
(7) How to detect and respond to signs of threatened and actual sexual abuse;
(8) How to avoid inappropriate relationships with residents;
(9) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; and
(10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities.

HPRC Policy 3.6 entitled Training, pages 1 and 2, section II(A)(1-10) address 115.231(a). This policy stipulates all new employees complete the National Institute of Corrections PREA training prior to having contact with residents. Additional training provided by HPRC shall be presented through PREA trainers via Power Point presentation, handouts, and audio-visual aides to all employees, volunteers and contractors who may have contact with residents on:

The facility's zero-tolerance policy for sexual abuse/sexual harassment;

How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies;
Residents' rights to be free from sexual abuse/sexual harassment;
Residents' and staffs' right to be free from retaliation when reporting sexual abuse and sexual harassment procedures;
The dynamics of sexual abuse and sexual harassment in confinement;
The common reactions of sexual abuse and sexual harassment victims;
How to detect and respond to signs of threatened and actual sexual abuse;
How to avoid inappropriate relationships with residents;
How to communicate effectively/professionally with residents and staff, including lesbian/gay/bisexual/transgender/questioning/intersex/gender nonconforming residents;
How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities.

The auditor has reviewed the following training resources that are provided to staff during Orientation and PREA Annual Refresher Training:

Guidance on Cross-Gender and Trans-Gender Pat Searches developed by the National PREA Resource Center in video, Power Point, Instructors Manual, and Webinar formats.

Gender Responsive Strategies produced by the National PREA Resource Center in Power Point format.

"What You Need to Know" produced by the National PREA Resource Center in video format.

PREA Refresher Course produced in Power Point format.

All ten of the requisite topics are addressed in these training resources. The training is tailored to both genders, although only male residents are housed at HPRC.

The auditor reviewed 46 HPRC staff signature receipts wherein staff certified their receipt, review, and understanding of certain PREA policies.

In addition to the above, the auditor reviewed PREA training files for 26 staff representing the Program Director, Deputy Director, BCS PREA Coordinator, Supervisor, Mental Health Counselor, Nurse, Security Specialists, Case Managers, and LACs. At HPRC, training is generally broken down by the course presented and participants each sign an HPRC Staff Development and Training Record Form, reflecting their signature for receipt and understanding of the information received. This is clearly commensurate with standard 115.231.

It is noted these files encompassed both PREA Orientation Training and In-Service training.

Pursuant to the auditor's review of these files, he also determined that nearly all staff files (25 of 26) contained one or more PREA on-line courses presented by the National Institute of Corrections, the Moss Group, or outside vendors or receipt of programs from MDOC. Clearly, the HPRC leadership and staff have embraced PREA sexual safety training, signifying above and beyond standard expectations with respect to this critical area. Accordingly, the auditor has determined HPRC staff have exceeded this standard.

All 12 random staff interviewees assert they have received training regarding the afore-mentioned topics. They have received this training during Orientation, dependent upon their entry on duty date with BACS, and during PREA Annual Refresher Training.

Pursuant to the PAQ, the PD self reports the training is tailored to the gender of the residents at the facility. The PD further self reports employees who are reassigned from facilities housing the opposite gender are given additional training.

HPRC Policy 3.6 entitled Training, pages 2 and 3, section II(G) addresses 115.231(b). This policy stipulates PREA training is required to be provided to employees, mental health practitioners, volunteers and contractors at a minimum of every two (2) years. Training shall address the needs of and be specific to the gender of the population housed within the facility.

According to the PREA Coordinator, staff transferring from ETC (female facility) receive the same training as that provided at HPRC, with the exception of the Gender Responsive Strategies and Cross-gender pat searches topics. Accordingly, staff transferees from ETC would receive these two training sessions.

Pursuant to the PAQ, the PD self reports that 25 staff employed by the facility, who may have contact with residents, were trained or retrained in PREA requirements. This represents 100% of staff employed by the facility, who may have contact with residents, who were trained or retrained in PREA requirements.

According to the PD, between trainings, staff receive additional PREA training pursuant to policy reviews which they certify as understanding the content of the same.

The PD self reports employees who may have contact with residents receive PREA Refresher Training on on an annual basis.

HPRC Policy 3.6 entitled Training, page 2, section II(C) addresses 115.231(d). This policy stipulates employee training shall be documented through employee signature that employees understand the training they have received. Specialized training will be required of medical and mental health, investigators, and the PREA Coordinator. The signed acknowledgment form will be maintained in the employee’s personnel files.

The auditor reviewed 10 employee training files during the course of the on-site audit. Documentation reflected the PREA courses completed by staff by date and signature and the caveat they understand the subject-matter presented. Additionally, copies of NIC and PREA Resource Center Certificates are also maintained in the files.

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? x□ 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)? x□ Yes □ No

115.232 (c)

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the PD self reports all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's policies and procedures regarding sexual abuse/harassment prevention, detection, and response.

The PD further self reports three volunteers and individual contractors who have contact with residents have been trained in agency policies and procedures regarding sexual abuse/harassment prevention, detection, and response.

HPRC Policy 3.6 entitled Training, page 2, section II(D) addresses 115.232(a). This policy stipulates volunteers and contractors who work with or have contact with residents will be trained on:

Responsibilities under the agency's sexual abuse/harassment prevention, detection, and response policies and procedures;
The zero-tolerance policy regarding sexual abuse and sexual harassment;
Method of reporting such incidents.

The contractor interviewee asserts he has been trained in his responsibilities regarding sexual abuse and sexual harassment prevention, detection, and response, per agency policy and procedure. As he works as both a contractor with a work program and he works part-time with Security, he receives PREA Annual Training. He has also received recent training.

Pursuant to the PAQ, the PD self reports the level and type of training provided to volunteers and contractors is based on the services they provide and level of contact they have with residents. The PD further self reports all volunteers and contractors who have contact with residents have been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.

HPRC Policy 3.6 entitled Training, page 2, section II(E) addresses 115.232(b). This policy stipulates 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, but all volunteers and contractors who have contact with residents shall be notified of HPRC's zero tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.

Review of PAQ materials reveals What You Need to Know (video) and Zero Tolerance, etc. (Power Point) was provided to volunteers. These resources clearly address the zero-tolerance policy regarding sexual abuse and sexual harassment and information regarding reporting. With regard to contractors, they are provided a document entitled PREA Compliance Acknowledgment (Contractors, Volunteers, and Visitors). This document addresses the afore-mentioned topics and contractors, volunteers, and visitors sign the same upon entry into the facility, attesting to their understanding of the contents of the document.

Volunteers and vendors also receive a copy of the PREA Brochure, providing additional information substantiating compliance with 115.232(b). Volunteers and contractors also sign a certification they have received the Brochure and BACS Policy 1.3.5.12, read, or had read to them, and understand the content of the same.

The contractor interviewee asserts training included interactions with LGBTI residents, cross-gender pat searches and searches of LGBTI/Intersex residents, reporting incidents of sexual abuse and sexual harassment, zero tolerance policy towards sexual abuse and sexual harassment, and the residents' right to be free from sexual abuse and sexual harassment.

Pursuant to the PAQ, the PD self reports the agency maintains documentation confirming that volunteers/contractors understand the training they have received.

HPRC Policy 3.6 entitled Training, page 2, section II(F) addresses 115.232(c). This policy stipulates the HPRC Program will maintain documentation confirming volunteers and contractors understand the training they have received.

Pursuant to contact with the BACS PREA Coordinator, HPRC does not possess training documentation verifying that volunteers and contractors understand the What You Need to Know video and Zero Tolerance et. al. training. Accordingly, HPRC is not in compliance with this standard provision.

To ensure compliance with this provision, a new form bearing the "I understand" caveat has been implemented for contractor and volunteer training. Pursuant to agreement between the PREA Coordinator and the auditor, the PREA Coordinator will use this form henceforth subsequent to provision of requisite training. Additionally, he will ensure that all current contractors/volunteers execute this form, subsequently forwarding copies of the same to the auditor. The PREA Coordinator has already commenced this process and the auditor has received numerous executed forms.

This process must be completed on or before April 24, 2018 to ensure the auditor can conclude review and assessment of corrective action prior to corrective action period closure (180 days from the date of this report). This provision can be closed prior to the afore-mentioned date based on the auditor's assessment.

12/18/2017 Update:

The auditor has received and reviewed 17 HPRC Volunteer/Contractor/Vendor Training Record Forms reflecting understanding of PREA information provided pursuant to a Power Point presentation and the PREA video. Previously, these individuals were brought into the facility on an infrequent basis.

Given the above, HPRC is now substantially compliant with 115.232(c).

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? x□ Yes □ No
- During intake, do residents receive information explaining: How to report incidents or suspicions of sexual abuse or sexual harassment? x□ Yes □ No
- During intake, do residents receive information explaining: Their rights to be free from sexual abuse and sexual harassment? x□ Yes □ No

- During intake, do residents receive information explaining: Their rights to be free from retaliation for reporting such incidents? x□ Yes □ No
- During intake, do residents receive information regarding agency policies and procedures for responding to such incidents? x□ Yes □ No

115.233 (b)

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

115.233 (c)

- Does the agency provide resident education in formats accessible to all residents, including those who: Are limited English proficient? x□ Yes □ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are deaf? x□ Yes □ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired? x□ Yes □ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are otherwise disabled? x□ Yes □ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Have limited reading skills? x□ Yes □ No

115.233 (d)

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the PD self reported residents receive information at time of intake about the zero-tolerance policy, how to report incidents or suspicions of sexual abuse or harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents. The PD further self reported 185 residents were given this information at Intake during the past 12 months. This equates to 100% of the total number of admissions during the past 12 months.

HPRC Policy 3.3 entitled Intake/Screening, pages 1 and 2, section II(A)(1)(a)(1-4) addresses 115.233(a). This policy stipulates during a Resident's admission into the facility, staff will:
Communicate to the Resident, verbally and in writing, information about the Prison Rape Elimination Act, including:
The program's zero tolerance policy regarding sexual activity, abuse, and/or harassment;
Information on prevention/intervention, self-protection, and availability of treatment and/or counseling;
Methods of reporting sexual abuse/harassment and consequences for false reporting;
Resident's right to be free from sexual abuse and sexual harassment and from retaliation for reporting an incident of sexual abuse or harassment.

In addition to the above, section II(A)(1)(e) and (f) of the same policy clearly reflects each resident will be given a copy of the Resident PREA Handbook and note the Resident's acceptance/denial of the handbook in the Resident's progress notes. Additionally, residents shall sign the Resident PREA Handbook/PREA Acknowledgment form, verifying they have been given this information.

The auditor reviewed 102 HPRC Handbook Receipts authored by residents at HPRC. The auditor is convinced the practice of resident education is institutionalized at HPRC.

All 19 of the random resident interviewees advise they received information about the facility's rules against sexual abuse and harassment when they first came to HPRC. Specifically, they generally received the PREA packet (PREA Handbook and PREA Brochure) at Intake and subsequently, they viewed the PREA video during Orientation/participated in Question and Answer. Additionally, all of the 19 random resident interviewees assert they were told about their right to not be sexually abused or sexually harassed, how to report sexual abuse or sexual harassment, and their right not to be punished for reporting sexual abuse or sexual harassment. Reportedly, they received this information at Intake and again within one week of arrival.

Both of the two Intake Staff interviewees assert residents are provided with information about the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment at Intake pursuant to receipt of the PREA Handbook/PREA Brochure. Additionally, residents are educated regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and

procedures for responding to such incidents pursuant to receipt of the PREA Handbook/PREA Brochure and during Orientation.

Pursuant to the PAQ, the PD self reports the facility provides residents who are transferred from a different community confinement facility with refresher information as described in 115.233(a). The PD further self reports that of the 71 residents received from a different community confinement facility, all received refresher information.

HPRC Policy 3.3 entitled Intake/Screening, page 2, section II(A)(1)(d) addresses 115.233(b). This policy stipulates HPRC training staff shall provide PREA orientation training within seven (7) days of admission whenever a resident is admitted to the HPRC to include residents transferred from a different facility.

All of the 19 random resident interviewees were received at HPRC from other facilities. All assert they received information as required in 115.233(a).

According to the two staff who perform Intakes, residents are made aware of the rights articulated in 115.233(a) immediately upon arrival (during Intake).

Pursuant to the PAQ, the PD self reports resident PREA education is available in accessible formats for all residents including those who are limited English proficient, deaf, visually impaired, otherwise disabled, as well as to residents who have limited reading skills.

HPRC Policy 3.3 entitled Intake/Screening, page2, section II(A)(1)(b) addresses 115.233(c). This policy stipulates HPRC will provide Resident education in formats accessible to all Residents, which will include written material and viewing the video “What You Need to Know”, including those who are limited English proficient by providing interpreters who speak the same language, deaf, visually impaired, or otherwise disabled as well as Residents who have limited reading skills by reading the information to them.

The auditor reviewed the HPRC PREA Handbook and finds the same to be comprehensive, well written, and commensurate with 115.233(a) and (c). The enlarged print version of the HPRC PREA Handbook is used with those residents who may have low vision capabilities.

Additionally, the PD self reported in a memorandum dated July 7, 2012, that he has an education background with special education and the mental health counselor would be utilized if the need arose for those with learning disabilities or residents who are low functioning.

In addition to the above, Montana Department of Corrections Probation and Parole Division Operational Procedure PPD 4.1.100, page 2, section III(A) and (B), corroborates the Executive Director's assertion. This policy stipulates (in the section entitled Requirements for Pre-Release Centers) that offenders will be physically and mentally capable of work, education, or vocational training. If they are unable to work due to a disability, i.e. a verified physical or mental handi-

cap, and/or they are eligible for Veterans Administration Benefits, SSI, or Vocational Rehabilitation Services, they must have a realistic plan to subsidize their stay at the PPD facility. In the section entitled Requirements for all Facilities, the policy stipulates that if an offender has a medical or psychological condition, facility staff and the facility's screening coordinator will assess the offender to determine if his/her needs can be met in a community-based setting.

Pursuant to the PAQ, the PD self reports the agency maintains documentation of resident participation in PREA education sessions.

HPRC Policy 3.3 entitled Intake/Screening, page 2, section II(A)(1)(d) and (f) addresses 115.233(d). This policy stipulates HPRC training staff shall provide PREA orientation training within seven (7) days of admission whenever a Resident is admitted to the HPRC to include residents transferred from a different facility. Additionally, residents shall sign the Resident PREA Handbook/PREA Acknowledgment form, verifying they have been given this information.

During the on-site audit, the auditor reviewed 10 random resident files, confirming that generally, PREA training commenced upon arrival at Intake with receipt of the PREA Handbook/PREA Brochure. Orientation followed either the same day up to and including seven days subsequent to arrival. Requisite resident signatures on Acknowledgment Forms/Orientation forms were present, signifying receipt of the PREA Handbook and/or PREA Brochure and PREA Orientation.

Pursuant to the PAQ, the PD self reports the agency ensures key information about the agency's PREA policies is continuously and readily available or visible through posters, resident handbooks, or other written formats.

HPRC Policy 3.3 entitled Intake/Screening, page 2, section II(A)(1)(c) addresses 115.233(e). This policy stipulates in addition to providing such education, HPRC shall ensure that key information is continuously and readily available or visible to Residents through posters, Resident handbooks.

Throughout the facility tour, the auditor noted the numerous PREA posters available in all areas of the facility. Posters are informative with telephone numbers, etc. Additionally, the auditor reviewed the PREA Handbook in entirety. The same captures relevant information commensurate with the PREA standards.

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 in-

vestigators have received training in conducting such investigations in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] x□ 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).] x□ 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).] x□ 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).] x□ 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).]
  x□ 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).]
  x□ 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*)

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

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

Pursuant to the PAQ, the PD self reports in addition to the general training provided to all employees pursuant to 115.231, the agency shall ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings.

HPRC Policy 3.6 entitled Training, page 3, section II(H)(1) addresses 115.234(a). This policy stipulates in addition to the general training provided to all employees pursuant to 115.231, the agency shall ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings.

According to the two Investigative staff interviewees, they completed the NIC Courses (Basic and Advanced Conducting Sexual Abuse Investigations in a Confinement Setting. The basic course was an overview, providing basics regarding interviewing, organizing the investigation, and legal parameters. The Advanced course was more intense with an actual practice case study. This included the conduct of mock interviews, Miranda and Garrity warnings, conduct of a mock investigation (step by step processing), and evidence collection.

HPRC Policy 3.6 entitled Training, page 3, section II(H)(2) addresses 115.234(b). This policy stipulates specialized Investigator training shall include techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral.

The auditor reviewed NIC Certificates for three staff (PREA- Investigating Sexual Abuse in a Confinement Setting: Basic and Advanced Investigations). Additionally, the auditor reviewed Certificates for both the Basic and Advanced courses (as reflected above) for the BACS PREA Coordinator. Pursuant to research of the NIC website, the training criteria referenced in the above policy is addressed.

According to the two Investigative interviewees, the specialized training referenced above addressed techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral.

Pursuant to the PAQ, the PD self reported the agency maintains documentation showing that investigators have completed the required training. The PD further self reports that four Administrative PREA Investigators are currently utilized at HPRC and that all four have completed requisite training.

HPRC Policy 3.4 entitled Training, page 3, section II(H)(3) addresses 115.234(c). This policy stipulates HPRC will maintain documentation that the facility's investigators have completed the required specialized training in conducting sexual abuse investigations.

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? x□ Yes □ No

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

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

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

115.235 (b)

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

115.235 (d)

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

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the agency has a policy related to the training of medical and mental health practitioners who work regularly in its facilities.

The PD self reported that the two medical and mental health care practitioners who work regularly at the facility received specialized training. This constitutes 100% of medical/mental health staff that received specialized training.

HPRC Policy 3.5 entitled Medical and Mental Health, pages 3 and 4, section III(A) addresses 115.235(a). This policy stipulates HPRC requires all part-time and full-time medical and mental health care practitioners who work regularly to attend the specialized training course offered through the NIC learning website or the Department of Corrections hands-on training that they may provide on the following:
How to detect and assess signs of sexual abuse and sexual harassment;
How to preserve physical evidence of sexual abuse;
How to respond effectively and professionally to victims of sexual abuse and sexual harassment;
How and to whom allegations/suspicions of sexual abuse/harassment should be reported.

According to the medical interviewee, she did receive the requisite specialty training. She completed regular PREA training and the NIC course for Medical regarding Sexual Abuse in a Confinement Setting. The course was a long course including "How to Collect Samples", How to Protect the Patient", and "Preparing the Patient for Transfer". Minimally, both the medical and mental health provider advise the training included information regarding detection and assessment of signs of sexual abuse and sexual harassment, how to preserve physical evidence of sexual abuse, how to respond effectively and professionally to victims of sexual abuse and sexual harassment, and how and to whom to report allegations or suspicions of sexual abuse and sexual harassment.

Pursuant to the PAQ, the PD self reports that forensic examinations are not conducted at HPRC. Such examinations would be conducted at a community hospital.

In view of the above, the auditor has determined provision (115.235(b) is not applicable to HPRC.

Pursuant to the PAQ, the PD self reports the agency shall maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere.

The auditor reviewed NIC Certificates and documentation certifying successful completion of the NIC PREA: Behavioral Health Care for Sexual Assault Victims in a Confinement Setting and PREA: Medical Care for Sexual Assault Victims in a Confinement Setting courses by the Medical and Mental Health staff employed at HPRC. Clearly, HPRC demonstrates compliance with this provision as both practitioners possess evidence substantiating completion of the requisite training.

The auditor reviewed training documentation for the medical/mental health providers at HPRC and has determined they did complete PREA courses provided to all HPRC staff. Specifically, the auditor reviewed HPRC Staff Development and Training Record Forms for both employees and finds they completed the following courses as part of In-Service training:

PREA- What You Need to Know;

Zero Tolerance Policy/Laws/Reporting, First Responder Duties;

Gender Responsive Strategies; and

Guidance on Cross-Gender and Trans-Gender Pat Searches.

Accordingly, the auditor finds this provision is clearly institutionalized at HPRC.

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? x□ 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? x□ Yes □ No

115.241 (b)

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

115.241 (c)

- Are all PREA screening assessments conducted using an objective screening instrument? x□ 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 dis-ability? x□ 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? x□ 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? x□ 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? x□ 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? x□ 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? x□ 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)? x□ 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? x□ 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? x□ 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? x□ 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? x□ 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? x□ 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? x□ Yes □ No

115.241 (g)

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

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

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the PD self reports the agency has a policy that requires screening (upon admission to a facility or transfer to another facility) for risk of sexual abuse victimization or sexual abusiveness toward other residents.

HPRC Policy 3.3 entitled Intake/Screening, pages 3 and 4, section II(B) addresses 115.241(a). This policy stipulates residents are screened by a Security Specialist through the use of the HPRC screening tool, within 24 hours of arrival at the facility, for potential vulnerabilities or tendencies of being sexually abused by other Residents or sexually abusive toward other Residents. Security staff meets with the Resident within twenty-four (24) hours and completes the medical and mental health – screening instrument. Medical staff will screen the Resident within seven (7) days.

According to one of the two staff who perform screening for risk of victimization and abusiveness interviewees, he/she screens residents upon admission to HPRC or transfer from another facility for risk of sexual abuse victimization or sexual abusiveness toward other residents. The other interviewee asserts he/she does not facilitate such screenings. He/she does not actually conduct Initial PREA Screenings. He/she asks the resident if they received an initial screening upon Intake during

the course of facilitation of the re-screening. He/she never received information that initial screening was not conducted.

Of the 19 random resident interviewees, 17 advised when they first arrived at HPRC, they were asked questions like whether they had been in jail or prison before, whether they had ever been sexually abused, whether they identify as being gay, lesbian, or bisexual and whether they think they might be in danger of sexual abuse at HPRC. All interviewees who responded in the affirmative asserted they were asked the above questions on the day of arrival, within one hour of arrival, and during Intake.

Of the random resident interviewees who arrived at HPRC and asserted they either did not recall being initially screened/were no initially, screened, the auditor reviewed their files and found both were screened upon arrival at HPRC. Screenings were conducted on the same date of arrival.

The auditor finds substantial compliance with 115.241(a).

Pursuant to the PAQ, the PD self reports policy requires that residents be screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their intake.

The PD further self reports that 107 residents entered the facility (either through intake or transfer) whose length of stay in the facility was for 72 hours or more, were screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their entry into the facility. This statement is based on residents admitted to HPRC since March, 2017.

The auditor reviewed 54 HPRC Risk Screening documents and found that all were completed on the day of arrival. The majority of the documents reflected clarification or expansion on issues relevant to PREA classification.

Pursuant to the staff who performs initial PREA screening interviewee, he/she asserts incoming residents are screened for risk of sexual victimization or risk of sexually abusing other residents at Intake, approximately within one hour of arrival.

Pursuant to the PAQ, the PD self reports risk assessment is conducted using an objective screening instrument. The auditor has reviewed the objective screening instrument and finds the same to meet the requirements of this provision.

Pursuant to the PAQ, the PD self reports the intake screening shall consider, at a minimum, the following criteria to assess residents for risk of sexual victimization:
(1) Whether the resident has a mental, physical, or developmental disability;
(2) The age of the resident;
(3) The physical build of the resident;
(4) Whether the resident has previously been incarcerated;
(5) Whether the resident's criminal history is exclusively nonviolent;

(6) Whether the resident has prior convictions for sex offenses against an adult or child;
(7) Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming;
(8) Whether the resident has previously experienced sexual victimization; and
(9) The resident's own perception of vulnerability.

HPRC Policy 3.3 entitled Intake/Screening, page 4, section II(B)(1) addresses 115.241(d). This policy stipulates the objective PREA screening instrument shall assess the resident's risk of sexual victimization through information pertaining to:
Whether the resident has a mental, physical, or developmental disability;
The age of the resident;
The physical build of the resident;
If the Resident has previously been incarcerated;
If the Resident's criminal history is exclusively nonviolent;
If the Resident has prior convictions for sex offenses against an adult or child;
If the Resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming ;
If the Resident has previously experienced sexual victimization;
The Residents' own perception of vulnerability;
The transgender or intersex Resident's gender identity; whether the Resident self-identifies as male or female.

The auditor reviewed the objective screening tool and finds that minimally, all of the requisite criteria are addressed in the HPRC Risk Screening.

In addition to the above, the screening tool is used to assess history of prior institutional violence or sexual abuse, as known to the agency. Specifically, there are questions that address both issues within a confinement setting. Additionally, residents are asked if they have a history of predatory behavior while institutionalized, including jail and whether they have an institutional history of sexual activity.

The screening tool is separated into Vulnerability Factors and Aggressive/Predatory Factors, with related questions in each section. At the bottom of each section, there is a matrix wherein specific responses to specific questions and cumulative responses to total questions are used to identify the resident being screened as a Known Victim or Potential Victim or Known Aggressor or Potential Aggressor. Additionally, there is a criteria for those residents who do not activate any of the key indicators specified in both sections. These residents are neither victims or aggressors.

The tool reflects the name of the resident, resident number, and assessment date. Additionally, there is a box wherein either Initial Assessment or Re-Assessment can be checked.

The auditor reviewed 54 HPRC Risk Screening documents and found that all of the requisite issues were addressed with a response. The majority of the documents reflected clarification or expansion on issues relevant to PREA classification.

Pursuant to conversation with the PD, the auditor learned that the PD reviews all packets related to residents he approves prior to the resident's designation to HPRC. Additionally, Case Managers review the same. Significant information germane to the PREA screening is passed along to staff facilitating the initial screening.

The staff who perform screening for risk of victimization and abusiveness interviewee asserts the initial screening tool considers whether resident is a Potential Victim/Potential Aggressor/Known Victim/Known Aggressor, identifies as LGBTI, is a violent offender, has a history of mental health issues, and is a member of a security threat group. Additionally, the screener's assessment and their feelings are integral to the process.

In regard to the process for conducting the initial screening, the Disclaimer is first addressed with the resident. The screening is conducted in a private setting. The screener uses the Screening Tool, asking the questions reflected above.

HPRC Policy 3.3 entitled Intake/Screening, page 4, section II(B)(2) addresses 115.241(e). This policy stipulates the intake screening shall consider prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to HPRC in assessing Residents for risk of being sexually abusive. If screening results indicate the Resident is likely to be an aggressor, or to be vulnerable to sexually abusive or assaultive behavior, the Program Director will be notified and the resident’s housing will be determined on a case by case basis.

As reflected in the narrative for 115.241(d), all of these components are addressed in the HPRC Risk Screening tool. The auditor has verified the same pursuant to review of the actual tool and its implementation.

Pursuant to the PAQ, the PD self reports the policy requires that the facility reassess each resident’s risk of victimization or abusiveness within a set time period, not to exceed 30 days after the resident’s arrival at the facility, based upon any additional, relevant information received by the facility since the intake screening. The PD further self reports 68 residents (since March, 2017) have entered the facility (either through intake or transfer) who were reassessed for their risk of sexual victimization or of being sexually abusive within 30 days after their arrival at the facility based upon any additional, relevant information received since intake.

HPRC Policy 3.3 entitled Intake/Screening, page 4, section II(B)(3) addresses 115.241(f). This policy asserts within a set time period, not to exceed 30 days from the Resident’s arrival at the facility, the facility’s Chemical Dependency Counselor will reassess the Residents’ risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening.

The auditor reviewed 24 Initial PREA Assessments with the accompanying Re-Assessments and determined 12 of the PREA Re-Assessments were facilitated outside the 30-day maximum threshold from the date on which the Initial PREA Assessment was conducted. Seven of the 12 Re-Assessments were facilitated within 31 or 32 days of the Initial PREA Assessment. The remaining five Re-Assessments were conducted within 34 to 45 days of the date of the Initial PREA Assessment.

The staff responsible for risk screening (re-assessments) interviewee asserts re-assessments are conducted on or before 30 days of arrival. Intake staff key the initial screening into the TOM system (offender management system). Subsequently, a Task list is generated that alerts the interviewee at the 25th day from arrival and the screener then facilitates the re-assessment.

Of the 19 random resident interviewees, five residents assert they received a re-assessment. Two interviewees assert they do not recall and three interviewees stated they didn't think they received a re-assessment. Nine interviewees assert they did not receive a PREA re-assessment.

The auditor reviewed nine resident files, as described in the following paragraph, related to these residents. Of those residents who advised they did not have a re-assessment, the auditor found that one did have a re-assessment, two did not have a re-assessment, and two received an untimely re-assessment. Of those that did not recall if they had a re-assessment, one did not have a re-assessment. Of those that didn't think they had a re-assessment, two did have a timely re-assessment while one had an untimely re-assessment.

During the HPRC on-site audit, the auditor reviewed 10 resident files and determined there was no re-assessment in four cases and the re-assessment was untimely in three additional cases.

In view of the above, provision 115.241(f) has been determined to be non-compliant. Given the tracking procedure currently implemented, the auditor finds that corrective action should be accomplished in an expeditious fashion.

Corrective action is comprised of the steps as follows. The BACS PREA Coordinator will forward a roster of dates of arrival for the next three to five months to the auditor. Additionally, copies of the corresponding re-assessment forms will likewise be forwarded to the auditor for review and comparison. A copy of the Initial PREA Assessment will also be included in this packet.

This process must be completed on or before April 24, 2018 to ensure the auditor can conclude review and complete an assessment of corrective action prior to corrective action period closure. As mentioned above, this provision can be closed prior to the afore-mentioned date based on the auditor's assessment.

12/18/2017 Update:

The auditor has received and reviewed three initial assessments and subsequent re-assessments, finding the same to have been facilitated within 30 days of the initial assessment.

1/11/2018 Update:

The auditor has received and reviewed 18 re-assessments and compared the same against a document entitled Room Assignment Based on PREA Risk Assessment (RABPRA) to determine timeliness of completion of the 30-day review. The RABPRA reflects date of arrival, initial classification date, and re-assessment date, along with other information. The auditor noted no discrepancies in terms of re-assessment timeliness and completion of the re-assessments.

02/15/2018 Update:

The auditor has received and reviewed three re-assessments and compared the same against a document entitled Room Assignment Based on PREA Risk Assessment (RABPRA) to determine timeliness of completion of the 30-day review. The Initial Assessments were conducted in December, 2017 and all re-assessments (30-day reviews) were completed in a timely manner. The RABPRA reflects date of arrival, initial classification date, and re-assessment date, along with other information. The auditor noted no discrepancies in terms of re-assessment timeliness and completion of the re-assessments.

The auditor finds HPRC to be compliant with 115.241(f).

Pursuant to the PAQ, the PD self reports the policy requires that a resident's risk level be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness.

HPRC Policy 3.3 entitled Intake/Screening, page 4, section II(B)(4) addresses 115.241(g). This policy stipulates a Residents' risk level shall be reassessed by HPRC staff when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the Residents risk of sexual victimization or abusiveness.

Pursuant to follow-up with HPRC staff, it has been learned that there were no reassessments completed within the past 90 days based on a referral, request, incident of sexual abuse, or receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness.

According to the staff member who facilitates PREA screening re-assessments, she facilitates all re-assessments. Re-assessments can be initiated pursuant to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness.

Pursuant to the PAQ, the PD self reports the policy prohibits disciplining residents for refusing to answer (or for not disclosing complete information related to) questions regarding:

• Whether or not the resident has a mental, physical, or developmental disability;
• Whether or not the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender non-conforming;
• Whether or not the resident has previously experienced sexual victimization; and
• The resident's own perception of vulnerability.

HPRC Policy 3.3 entitled Intake/Screening, page 5, section II(B)(6) addresses 115.241(h). This policy stipulates Residents may not be disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to this section.

According to the staff responsible for risk screening (initial and re-assessments) interviewees, residents are not disciplined in any way for refusing to respond to or for not disclosing complete information related to:
• Whether or not the resident has a mental, physical, or developmental disability;
• Whether or not the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender non-conforming;
• Whether or not the resident has previously experienced sexual victimization; and
• The resident's own perception of vulnerability.

Prior to administration of the screening tool, the resident signs a Disclaimer Form which stipulates there will be no discipline for refusal or failure to respond to the afore-mentioned specific questions.

HPRC Policy 3.3 entitled Intake/Screening, page 5, section II(B)(7) addresses 115.241(i). This policy stipulates HPRC shall implement 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. HPRC enforces the breach of confidentiality through personnel and HPRC policies.

According to the BACS PREA Coordinator, the PD, PREA Coordinator, and the screener constitute the individuals who have access to a resident's risk assessment within the facility in order to protect sensitive information from exploitation. The two staff responsible for risk screening corroborated the statement of the BACS PREA Coordinator, stating the PD and PREA Coordinator are the primary links in the screening informational chain.

The auditor has determined that information dissemination controls are sufficient to meet the requirements of 115.241(i).

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? x□ 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? x□ 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? x□ 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? x□ 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? x□ Yes □ No

115.242 (b)

- Does the agency make individualized determinations about how to ensure the safety of each resident? x□ 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)? x□ 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? x□ 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? x□ Yes □ No

115.242 (e)

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

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

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

Auditor Overall Compliance Determination

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

x☐ **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

Pursuant to the PAQ, the PD self reports the facility uses information from the risk screening 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.

HPRC Policy 3.3 entitled Intake/Screening, page 5, section II(C)(2) addresses 115.242(a). This policy stipulates HPRC shall use information, through the use of access to the server, from the risk screening 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.

At HPRC, a daily room assignment or count sheet is used to track bed/room assignments. Potential Victims (PV) are highlighted in yellow and Potential Predators (PP) are highlighted in blue. The auditor reviewed documents for ten days and found that PVs were housed with PPs on two occasions. The documents were quite thoroughly screened to determine if patterns were prevalent, etc. and the auditor finds this not to be the case. It is noted that the situation was reportedly addressed when detected and it resulted in no known issues.

The auditor also reviewed one document entitled Room Assignment Based on PREA Risk Assessment which accomplishes the same end as described in the preceding paragraph. Potential predators are highlighted in red while potential victims are highlighted in brown. A thorough review of this document revealed no potential victims or predators were housed together.

According to the PREA Coordinator, risk screening information is translated into PAs, PVs, KAs, and KVs and they are geographically separated by room or wing. Staff are aware of the labeling and extra precautions may be employed. According to the two staff responsible for risk screening, information gleaned from the risk screening is used to make housing and programming sexual safety decisions.

Pursuant to the PAQ, the PD self reports the agency shall make individualized determinations about how to ensure the safety of each resident.

HPRC Policy 3.3 entitled Intake/Screening, page 6, section II(C)(3) addresses 115.242(b). This policy stipulates the Program Administrator, Security Supervisor, and PREA Manager shall make individualized determinations about how to ensure the safety of each Resident.

The schematic for ensuring resident sexual safety is stipulated in the narrative for 115.242(a).

Pursuant to the PAQ, the PD self reports the facility would make housing and program assignments for transgender or intersex residents in the facility on a case-by-case basis.

HPRC Policy 3.3 entitled Intake/Screening, page 6, section II(C)(4) and (5) addresses 115.242(c). This policy stipulates in deciding whether to assign a transgender or intersex Resident to a facility for male or female Residents, and in making other housing and programming assignments, including possible transfer to another facility if most appropriate, HPRC shall consider on a case-by-case basis whether a placement would ensure the Resident's health and safety, and whether the placement would present management or security problems. HPRC will consider facility factors, including Resident populations, staffing patterns, and physical layouts. Best practices include initial consultation and multiple reviews of a transgender or intersex Resident's housing and programming plan with administration, security, medical and mental health staff. Housing and programming must allow for gender identity when appropriate.

Although no transgender/intersex residents were housed at HPRC during the on-site audit, the PREA Coordinator advised staff and resident's perceptions of personal safety would be a primary consideration when determining housing and programming assignments. Genitalia may not be the primary consideration in the final analysis. There are no specific wings or facilities wherein transgender/intersex residents are housed. The resident's health and safety is always a consideration in terms of placement. Additionally, management and security problems would be a consideration in terms of placement.

HPRC Policy 3.3 entitled Intake/Screening, page 6, section II(C)(6) addresses 115.242(d). This policy stipulates a transgender or intersex Resident's own views with respect to his own safety shall be given serious consideration.

The PREA Coordinator asserts that a transgender/intersex resident's own views with respect to his own safety would be given serious consideration in placement and programming assignments. The two staff responsible for risk screening also assert that a transgender/intersex resident's own view of his safety would be given serious consideration in placement and programming assignments. The question is asked on the Screening Tool.

HPRC Policy 3.3 entitled Intake/Screening, page 7, section II(C)(9) addresses 115.242(e). This policy stipulates transgender and intersex Residents shall be given the opportunity to shower separately from other Residents.

The auditor learned that a shower(s) would be shut down during shower periods in which transgender/intersex residents shower. During the tour, the auditor discussed such shower operations with staff, finding that they were aware of the same and operational procedures employed in terms of such showering arrangements. Staff would supervise the shower period.
The auditor finds the arrangement to be suitable for its purpose.

Both staff responsible for risk screening advised there is a procedure for showering transgender/intersex residents separate from the remainder of the population, if they so choose. One interviewee corroborated the statement of the PREA Coordinator, asserting bathrooms would be locked down from other residents. Staff would monitor showers to ensure no entry.

HPRC Policy 3.3 entitled Intake/Screening, page 7, section II(C)(10) addresses 115.242(f). This policy stipulates HPRC shall not place lesbian, gay, bisexual, transgender, or intersex Residents in dedicated facilities, units, or wings solely on the basis of such identification or status, unless such 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 such Residents.

According to the PREA Coordinator, BACS is not subject to a consent decree, legal settlement, or legal judgment requiring that it establish a dedicated facility, unit, or wing for lesbian, gay, bisexual, transgender, or intersex residents. Additionally, there are no specialized wings at either HPRC or ETC wherein such housing arrangements are effected.

The two LGBTI interviewees validated the statements of staff, asserting they have not been placed in a housing area designated for only LGBTI residents.

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? x□ 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? x□ 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? x□ 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? x□ 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? x□ Yes □ No
- Does that private entity or office allow the resident to remain anonymous upon request? x□ 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? x□ Yes □ No
- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? x□ Yes □ No

115.251 (d)

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the PD self reports the agency has established procedures allowing for multiple internal ways for residents to report privately to agency officials about:
• Sexual abuse or sexual harassment;
• Retaliation by other residents or staff for reporting sexual abuse and sexual harassment; and

• Staff neglect or violation of responsibilities that may have contributed to such incidents.

HPRC Policy 3.4 entitled Reporting, page 1, section II(A)(2) addresses 115.251(a). This policy stipulates staff shall inform residents on the multiple internal ways (another staff, write a letter, call one of the numbers listed) to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents through resident intake, and orientation. Also, refer to resident PREA Section of the Resident Handbook.

The auditor reviewed the HPRC PREA Handbook and determined that resident reporting options are scripted on page 4, section entitled How to Report an Incident of Sexual Abuse. Reporting to an agency external to HPRC is also addressed in this section. The names and addresses of HPD and Safe Space are provided.

All 12 random staff interviewees were able to identify at least three resident reporting options with respect to the above. Options ranged from reporting to staff, contacting HPD, submission of an Emergency Grievance, advising community physician, Third Party Report, contact the PREA Hotline, and submit a kite.

Of the 19 random resident interviewees, only two articulated one reporting option. A third resident identified two reporting options. The remaining 16 random residents articulated three or more options, with some asserting that telephone numbers could be gleaned from posters. Reporting options quoted were reporting to staff, send a kite to the PD/Security Coordinator, telephone HPD or MDOC, Third Party Report, submit an Emergency Grievance, contact the Hotline, and advise family. All 19 random resident interviewees were able to identify someone or an entity external to the facility who could report an incident. Options included contacting the PREA Hotline and family/ friends who could submit a Third Party Report.

Pursuant to the PAQ, the PD self reports the agency provides at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the agency.

HPRC Policy 3.4 entitled Reporting, page 2, section II(A)(3-5) addresses 115.215(b). This policy stipulates staff and residents may report abuse, harassment, retaliation, or neglect, to any staff, director, volunteer, parole officer, attorney, or Safe Space.

Information about how to report sexual abuse and sexual harassment for a resident, staff, and outside agencies will be posted in the facility.

Contact information for Safe Space, a rape crisis center and victim advocate program, will be posted next to phones. Reports to this agency allow the resident to remain anonymous upon request.

The auditor reviewed the MOU between HPRC and Safe Space and finds that the same is commensurate with this provision. Safe Space represents one method for residents to report sexual abuse to an entity external to the facility.

According to the PREA Coordinator, residents may report incidents as referenced in 115.251(a) to Safe Space or Friendship Center, HPD, Jefferson County Sheriff Department. There are MOUs with all of the above. These procedures do enable receipt and immediate transmission of resident reports of sexual abuse and sexual harassment to agency officials that allow the resident to remain anonymous upon request. Pursuant to the MOU, the process enables immediate reporting to the PD and/or COO.

As mentioned in the narrative for 115.251(b), several of the 19 random resident interviewees assert incidents can be reported to the Hotline, HPD, or MDOC. Additionally, family/friends can submit a Third Party Request.

Pursuant to the PAQ, the PD self reports the agency has a policy mandating that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties. The PD further self reports staff are required to immediately document the verbal report.

HPRC Policy 3.4 entitled Reporting, page 2, section II(A)(7) addresses 115.251(c). This policy stipulates in the event that sexually abusive or assaultive behaviors are alleged, threatened, or have occurred, staff will take immediate action to intervene and ensure the safety of all persons involved. Staff will immediately document all reports and notify their Shift Supervisor, who will then consult with the Program Administrator for guidance.

Pursuant to the auditor's review of the one sexual harassment investigation, it is clear that the information was received on August 23, 2017 and the same was documented immediately.

All 12 random staff interviewees assert that when a resident alleges sexual abuse, he can do so verbally, in writing, anonymously, and from third parties. Staff unanimously assert they would immediately document such reports.

All of the 19 random resident interviewees assert residents can make reports of sexual abuse or sexual harassment either in person or in writing. While three interviewees were uncertain whether a report could be made by a Third Party so that the resident did not have to be named, sixteen responded in the affirmative. The three interviewees advised they thought a name was critical to initiation of an investigation.

Pursuant to the PAQ, the PD self reports the agency has established procedures for staff to privately report sexual abuse and sexual harassment of residents. The PD further self reports staff can verbally,written, electronically or via mail submit a report. Third party reporting forms are a means as well.

HPRC Policy 3.4 entitled Reporting, page 1, section II(A)(1) addresses 115.251(d). This policy stipulates staff members may make private reports to the Program Director or Security Supervisor in any timely manner to include via cell phone, facility extension, in private communications within the office of the Program Director or Security Supervisor, via agency email, or to a third party entity such as HPD, Safe Space, or the Friendship Center. Residents may report in any of the same manner as listed above with the exception of access to private or secure staff cell phone numbers.

As reflected in the narrative for 115.231, staff receive training regarding reporting options. The same is provided in the form of a Power Point presentation.

All of the 12 random staff interviewees were able to identify at least three methods to privately report sexual abuse and sexual harassment of residents. Reporting methods included, but were not limited to: contact HPD; Contact HPRC PD; e-mail PD or Security Coordinator; contact PD/Security Coordinator cell phone; report to supervisor; report to Lewis and Clark Sheriff Department; and drop a note in the Emergency Grievance Box.

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. x□ Yes □ No □ NA

115.252 (b)

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the PD self reports the agency has an administrative procedure for dealing with resident grievances regarding sexual abuse.

HPRC Policy 3.4 entitled Reporting, pages 3,4, and 5, section II(A)(13)(a-f) addresses 115.252(a).

Pursuant to the PAQ, the PD self reports agency policy or procedure allows a resident to submit a grievance regarding an allegation of sexual abuse at any time regardless of when the incident is alleged to have occurred. The PD further self reports agency policy does not require a resident to use an informal grievance process, or otherwise to attempt to resolve with staff, an alleged incident of sexual abuse.

HPRC Policy 3.4 entitled Reporting, page 3, section II(A)(a-d) addresses 115.252(b). This policy stipulates:

HPRC shall not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse. Any report given shall be dealt with immediately by the Program Administrator and the Security Coordinator.

HPRC may apply otherwise-applicable time limits on any portion of a grievance that does not allege an incident of sexual abuse. This coincides with the HPRC Resident Grievance process.

HPRC shall not require a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse. Residents are advised upon entry to use the emergency grievance form located on the unit or to contact staff immediately to report any alleged incident of sexual abuse or sexual harassment.

Nothing in this section shall restrict HPRC's ability to defend against a lawsuit filed by a resident on the ground that the applicable statute of limitations has expired.

The auditor has reviewed the HPRC PREA Audit Handbook and finds the requisite information identified in this provision is accurately captured at page 6, section entitled Grievance Procedure (a). This provision stipulates:

(1) The HELENA PRE-RELEASE CENTER Treatment Program will not impose a time limit on when a family member may submit a grievance regarding an allegation of sexual abuse.
(2) HELENA PRE-RELEASE CENTER may apply otherwise-applicable time limits on any portion of a grievance that does not allege an incident of sexual abuse.
(3) HELENA PRE-RELEASE CENTER will not require a family member to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse.
(4) Nothing in this section will restrict HELENA PRE-RELEASE CENTER's ability to defend against a lawsuit filed by a family member on the ground that the applicable statute of limitations has expired.

Pursuant to the PAQ, the PD self reports agency policy and procedure allows a resident to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint. The PD further self reports agency policy and procedure requires that a resident grievance alleging sexual abuse not be referred to the staff member who is the subject of the complaint.

HPRC Policy 3.4 entitled Reporting, page 4, section II(A)(13)(e)(5) addresses 115.252(c). This policy stipulates HPRC shall ensure that— (1) A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint. Grievance forms are located on all units of the HPRC facility, and there is a locked grievance box as well for all residents and (2) Such grievance is not referred to a staff member who is the subject of the complaint. Grievances are reviewed by the Security Coordinator and Program Administrator.

The auditor has reviewed the HPRC PREA Handbook and finds the requisite information identified in this provision is accurately captured at page 7, section entitled Grievance Procedure (b). This provision stipulates:

(1) A family member who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint, and
(2) Such grievance is not referred to a staff member who is the subject of the complaint.

Pursuant to the PAQ, the PD self reports agency policy and procedure requires that a decision on the merits of any grievance or portion of a grievance alleging sexual abuse be made within 90 days of the filing of the grievance. The PD further self reports that zero grievances have been filed (alleging sexual abuse) during the past 12 months. In cases where the agency requested an extension of the 90-day period to respond to a grievance and had reached final decisions by the time of the PREA audit, there were no grievances that took longer than a 70-day extension period to resolve. Finally, the PD self reports the agency would always notify the resident, in writing, when the agency files for an extension, including notice of the date by which a decision will be made.

HPRC Policy 3.4 entitled Reporting, pages 4 and 5, section II(A)(13)(f)(1-4) addresses 115.252(d). This policy stipulates:

HPRC shall 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 shall not include time consumed by residents in preparing any administrative appeal;

HPRC may claim an extension of time to respond, of up to 70 days, if the normal time period for response is insufficient to make an appropriate decision. HPRC shall notify the resident in writing of any such extension and provide a date by which a decision will be made.

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, the resident may consider the absence of a response to be a denial at that level.

It is noted there were no residents who reported a sexual abuse at HPRC during the on-site audit.

Pursuant to the PAQ, the PD self reports agency policy and procedure permits third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse and to file such requests on behalf of residents. The PD further self reports agency policy and procedure requires that if the resident declines to have third-party assistance in filing a grievance alleging sexual abuse, the agency documents the resident's decision to decline. There were zero grievances alleging sexual abuse filed by residents in the past 12 months in which the resident declined third-party assistance, containing documentation of the resident's decision to decline.

HPRC Policy 3.4 entitled Reporting, page 8, section II(D)(2) and (3) address 115.252(e). This policy stipulates:

Third parties, including fellow residents, staff members, residents, attorneys, family members, and outside advocates, shall be permitted to assist residents in filing requests for administrative remedies, such as filing grievances relating to allegations of sexual abuse and sexual harassment, and will also be permitted to file such requests on behalf of residents.

If a third party files a grievance on behalf of the 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. Should the alleged victim decline to have the request filed on his or her behalf, the center shall document the resident's decision.

Pursuant to the PAQ, the PD self reports the agency has a policy and established procedures for filing an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse. The PD further self reports agency policy and procedure for emergency grievances alleging substantial risk of imminent sexual abuse requires an initial response within 48 hours. There were no emergency grievances filed during the past 12 months, alleging substantial risk of imminent sexual abuse. According to the PD, agency policy and procedure for emergency grievances alleging substantial risk of imminent sexual abuse requires that a final agency decision be issued within five days.

HPRC Policy 3.4 entitled Reporting, page 3, section II(A)(13)(e)(1 and 2) addresses 115.252(f). This policy stipulates HPRC has an emergency grievance procedure in place for alleging a resident is in imminent risk of sexual abuse or sexual harassment. All emergency grievances are dealt with immediately and an initial response will be provided within 48 hours upon receipt.

Upon receiving an emergency grievance, the Security Coordinator along with Program Administrator shall review and make a final decision within 5 calendar days.

The initial response and final decision shall document HPRC's determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance. This decision shall be documented by the Program Administrator.

Pursuant to the PAQ, the PD self reports the agency has a written policy that limits its ability to discipline a resident for filing a grievance alleging sexual abuse to occasions where the agency demonstrates that the resident filed the grievance in bad faith. The PD further reports in the past 12 months, there were no resident grievances alleging sexual abuse that resulted in disciplinary action by the agency against the resident for having filed the grievance in bad faith.

HPRC Policy 3.4 entitled Reporting, page 4, section II II(A)(13)(e)(3) addresses 115.252(g). This policy stipulates HPRC may discipline a resident for filing a grievance related to alleged sexual abuse only where HPRC demonstrates that the resident filed the grievance in bad faith.

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? x□ Yes □ No

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

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the PD self reports the facility provides 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) for local, state, or national victim advocacy or rape crisis organizations;

Enabling reasonable communication between residents and these organizations in as confidential a manner as possible.

HPRC Policy 3.5 entitled Medical and Mental Health, page 2, section II(B)(1) addresses 115.253(a). This policy stipulates HPRC provides residents with access to outside victim advocates through Safe Space and other outside agencies 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, and by enabling reasonable communication between residents and these organizations, in as confidential a manner as possible. These numbers are posted near the phones and throughout the facility as well as located in the PREA section of the Resident Handbook. PREA brochures are located throughout the facility as well.

The auditor has reviewed the HPRC PREA Handbook and notes addresses and telephone numbers for Safe Space on pages 5 and 6 of the same. Additionally, addresses and telephone numbers are reflected on posters and available pursuant to resident contact with their case manager.

The auditor also reviewed the MOUs with Safe Space and The Friendship Center and finds the same to be in compliance with this provision including, confidentiality language with respect thereof.

All of the 19 random resident interviewees relate they know there are services available outside of the facility for dealing with sexual abuse, if needed. Twelve of the 19 interviewees identified specific services that are available. Several others who could not specifically identify available services stated such information is available on posters located in bathrooms, posted on walls, posted near resident telephones. Sixteen of the 19 interviewees assert addresses and telephone numbers are identified in the PREA Handbook and on the afore-mentioned posters. Finally, seventeen of the 19 interviewees asserted they could talk to people from these services at anytime.

Clearly, random resident interviewees were quite knowledgeable regarding outside services. As mentioned throughout this report, the PREA Handbook is comprehensive, providing valuable information for residents to consume. Minimally, interviewees were aware of the resources available to them.

As previously mentioned, no residents who reported a sexual abuse were housed at HPRC during the on-site audit.

Pursuant to the PAQ, the PD self reports the facility informs residents, prior to giving them access to outside support services, of the extent to which such communications will be monitored. The PD further self reports the facility informs residents, prior to giving them access to outside support services, of the mandatory reporting rules governing privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant federal, state, or local law.

HPRC Policy 3.5 entitled Medical and Mental Health, page 2, section II(B)(2and 3) addresses 115.253(b). This policy stipulates HPRC shall 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 regarding PREA incidents. HPRC has entered into a memoranda of understanding with Safe Space to provide emotional support services.

Confidentiality is generally addressed on page 4 of the HPRC PREA Handbook entitled Resident Access to Outside Confidential Support Services.

Seventeen of the 19 random resident interviewees asserted that what they say to people representing the service agencies addressed in the narrative for 115.253(a), remains private. Thirteen of the 19 interviewees identified specific instances when such conversations may be shared or listened to by others. Examples cited were for law enforcement use in the event of a sexual abuse or continuing sexual abuse, medical practitioners/mental health providers in the event of resultant suicidal ideations, and mandatory reporting scenarios. As mentioned in the narrative for 115.253(a), residents are generally aware of resources from which to research answers to questions regarding the subject-matter of 115.253(b).

Pursuant to the PAQ, the PD self reports the agency or facility maintains memoranda of understanding (MOUs) or other agreements with community service providers that are able to provide residents with emotional support services related to sexual abuse. The PD further self reports the facility maintains copies of these agreements.

Discussion of the MOUs with Safe Space and The Friendship Center have been addressed in the narratives for 115.253(a) and (b).

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? x□ Yes □ No

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the PD self reports the facility provides a method to receive third-party reports of resident sexual abuse or sexual harassment. A Third Party reporting form is located on all floors and the www.boydandrew.com website. All reports go directly to the PREA Coordinator who, in turn, distributes the same to each facility. All phone calls are taken by the PD or PREA Manager at the facility. If the PREA Coordinator is contacted, he immediately contacts the PD. Emails are another source of receiving third party reports and they are brought to the PD immediately.

The auditor reviewed the BACS Third-Party Reporting Form and determined the same is comprehensive and commensurate with the standard. The name, address, and telephone number of the PREA Coordinator are clearly reflected in the document. Contact information for the reporter consists of name, telephone, and best time to contact. Description of Incident information includes date of the alleged incident, names of offender(s) and staff involved, type of incident (sexual abuse, sexual harassment, unknown), facility wherein offender resides, and the facility wherein the alleged incident occurred, and finally, a description of the alleged incident.

According to the PD, no Third-Party reports have been submitted during the past 12 months.

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? x□ 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? x□ 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? x□ 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? x□ 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? x□ 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? x□ 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? x□ 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? x□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the PD self reports staff must report immediately and according to policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency;

Any retaliation against residents or staff who reported such an incident;

Any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

HPRC Policy 3.4 entitled Reporting, page 6, section II(C)(1) addresses 115.261(a). This policy stipulates staff, volunteers, and contractors will immediately report to the Program Administrator or Security Coordinator any knowledge, suspicion, or information they receive regarding an incident of

sexual abuse or sexual harassment that occurred at the HPRC facility, and any other facility, whether or not the facility is part of BACS, retaliation against residents or staff who report such an incident, any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

All of the 12 random staff interviewees advise that all staff must report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. All interviewees advise verbal reports must be effected immediately to the PD, Deputy Director, Security Coordinator, Shift Supervisor, and/or PREA Coordinator.

Pursuant to the PAQ, the PD self reports apart from reporting to designated supervisors or officials and designated state or local service agencies, agency policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions.

HPRC Policy 3.4 entitled Reporting, page 6, section II(C)(3) addresses 115.261(b). This policy stipulates staff will take pictures of visible signs of injury except in cases where the injury is to the genitals or breasts. Other evidence shall be preserved and protected. Apart from reporting to Program Administrator, Security Coordinator, Shift Supervisor or officials, staff shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in HPRC policy, to make treatment, investigation, and other security and management decisions.

HPRC Policy 3.4 entitled Reporting, pages 6 and 7, section II(C)(5) addresses 115.261(c). This policy stipulates unless otherwise precluded by Federal, state, or local law, medical and mental health practitioners shall be required to report sexual abuse pursuant to paragraph (1) of this section, regarding 115.261, and to inform residents of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services.

Both medical and mental health interviewees advise that at the initiation of services to a resident, they disclose the limitations of confidentiality and their duty to report. They are also required to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment to a designated supervisor or official immediately upon learning of the same. This is a policy requirement. Neither interviewee has ever become aware of such incidents.

HPRC Policy 3.4 entitled Reporting, page 6, section II(C)(4) addresses 115.261(d). This policy stipulates if the alleged victim is under the age of 18 or considered a vulnerable adult under a state or local vulnerable person's statute, HPRC shall report the allegation to the designated state or local services agency under applicable mandatory reporting laws.

As reported to the auditor by the BACS PREA Coordinator, no residents meeting the criteria of the Montana Elder and Persons with Developmental Disabilities Abuse Prevention Act, have been housed at HPRC during the past 12 months.

According to the PD, juveniles and vulnerable adults are not housed at HPRC. Nobody under the age of 18 nor DHHS commitments are housed at HPRC. The same was again substantiated during the PREA Coordinator's interview.

HPRC Policy 3.11 entitled Coordinated Response/Staff First Responder Duties, page 1, section II(1 and 2) addresses 115.261(e). This policy stipulates all staff, volunteers and contractors of HPRC staff shall immediately report to the Shift Supervisor, Security Supervisor, or Program Administrator any knowledge, suspicion, or information they receive regarding any incident of resident sexual abuse or resident sexual harassment.

The Program Administrator or designee of HPRC shall ensure an investigation is conducted.

According to the PD, he is the PREA Investigator. Reports would come directly to him and he would initiate an investigation.

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? x□ Yes □ No

Auditor Overall Compliance Determination

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

x☐ **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

Pursuant to the PAQ, the PD self reports when the agency or facility learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident (i.e., it takes some action to assess and implement appropriate protective measures without unreasonable delay). The PD further self reports in the past 12 months, there was 0 times the facility determined a resident was subject to substantial risk of imminent sexual abuse.

HPRC Policy 3.4 entitled Reporting, page 2, section II(A)(7) addresses 115.262(a). This policy stipulates in the event that sexually abusive or assaultive behaviors are alleged, threatened, or have occurred, staff will take immediate action to intervene and ensure the safety of all persons involved. Staff will immediately document all reports and notify their Shift Supervisor, who will then consult with the Program Administrator for guidance.

In response to protective action taken when it is learned that a resident is or may be subject to a substantial risk of imminent sexual abuse, the BACS CEO asserts an investigation and monitoring are initiated. Provision of emotional support is also initiated. The resident would be moved to a safe place and the shift supervisor would be notified to intensify rounds.

In response to a similar question, the PD asserts the potential victim will be placed in a safe place (e.g. closer to the duty station). An attempt is made to identify potential perpetrator(s). Potential perpetrator(s) might be moved to Helena County Jail. Affected resident(s) might be moved to different wings. Safety checks would be increased. We might work with Probation and the Courts to effect quick (early) releases or conditional releases, if warranted.

All 12 random staff interviewees assert that if it was learned a resident was at risk of imminent sexual abuse, they would remove the potential victim from harm's way, generally monitoring him while they report and document. Some interviewees advised they would assign staff to discretely monitor any known or suspected potential perpetrator(s). Actions would be initiated immediately.

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? x□ Yes □ No

115.263 (b)

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

115.263 (c)

- Does the agency document that it has provided such notification? x□ 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? x□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the PD self reports the agency has a policy requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility must notify the head of the facility or appropriate office of the agency or facility where sexual abuse is alleged to have occurred. The PD further self reports there were 0 allegations received during the past 12 months, that a resident was abused while confined at another facility.

HPRC policy 3.4 entitled Reporting, page 7, section II(C)(10) addresses 115.263(a). This policy stipulates if staff receives information that a resident was sexually abused or sexually harassed while confined in another facility they will immediately report it to the Program Administrator. The Program Administrator will then notify the head of the facility where the alleged abuse occurred within seventy-two (72) hours. Documentation of notification will be maintained in the Program Administrator's office. Once notification is made, it is up to the facility head or agency office which received notification to ensure the allegation is fully investigated according to state law and PREA standards.

Pursuant to the PAQ, the PD self reports agency policy requires the facility head provides such notification as soon as possible, but no later than 72 hours after receiving the allegation. The policy provision is addressed in the narrative for 115.263(a).

Pursuant to the PAQ, the PD self reports the agency or facility documents that it has provided such notification within 72 hours of receiving the allegation.

Pursuant to the PAQ, the PD self reports the agency or facility policy requires that allegations received from other facilities/agencies are investigated in accordance with the PREA standards. The PD further self reports in the past 12 months, there was zero allegations of sexual abuse that were received from other facilities regarding incidents allegedly arising at HPRC.

When questioned as to the designated point of contact at HPRC for receipt of allegations of sexual abuse or sexual harassment referred from another administrator regarding an incident allegedly occurring at HPRC, the CEO advises such report would be directed to the PD. If the alleged incident occurred at our facility, the investigation would be initiated at HPRC. No such referrals were received at HPRC that the CEO recalled.

When an allegation is received from another facility or agency regarding an incident of sexual abuse or sexual harassment that allegedly occurred at HPRC, the PD asserts an investigation would be initiated. The alleged victim resident would be interviewed at his current facility. The PD would re-

port his findings to the Warden of the current institution upon conclusion of the investigation and findings would subsequently be reported to MDOC.

The PD reported there are no examples of another facility or agency reporting such allegations.

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? x□ 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? x□ 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? x□ 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? x□ 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? x□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the PD self reports the agency has a first responder policy for allegations of sexual abuse. The PD further self reports the agency policy requires that, upon learning of an alle-

gation that a resident was sexually abused, the first security staff member to respond to the report shall be required to:

(1) Separate the alleged victim and abuser;
(2) Preserve and protect any crime
scene until appropriate steps can be taken to collect any evidence;
(3) If the abuse occurred within a time period that still allows for the collection of physical evidence, 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; and
(4) If the abuse occurred within a time period that still allows for the collection of physical evidence, 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.

During the past 12 months, there were zero allegations of resident sexual abuse at HPRC.

HPRC Policy 3.11 entitled Coordinated Response/Staff First Response Duties, pages 1 and 2, section II(A)(1)(a-m) addresses 115.264(a). This policy stipulates the first staff member responding at an allegation of sexual abuse must:
Physically separate the alleged victim from the alleged abuser;
Notify all necessary staff (immediate supervisor, administrator, medical, mental health) of HPRC;
Address the need for acute medical treatment and contact community medical (hospital) personnel if needed;
Follow universal precautions for bodily fluids;
Ensure a staff member stays with the alleged victim until the alleged victim is placed in the care of another staff member such as mental health or medical personnel;
Preserve and protect any potential crime scene until law enforcement arrives;
Escort residents to “dry” areas where water may not be accessed, ensuring sight and sound separation of alleged victim and alleged abuser;
If the alleged abuse occurred within 96 hours, first responder staff shall immediately request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, drinking, or eating;
Refrain from asking alleged victim detailed questions about the incident to avoid possible traumatization;
If the abuse occurred within 72 hours, first responder staff shall immediately ensure that the alleged perpetrator not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating;
Ensure pictures are taken of any scratches, abrasions, wounds, or other visible signs of injury except in cases where the injury is to the genitals or breasts;
One security staff member is to supervise each resident (alleged victim and alleged offender). One staff member or mental health staff member will stay with alleged victim until alleged victim is

placed in the care of another staff member via directive of supervision of security staff or administrator;
Consult with Supervisor and complete the necessary significant incident report. This incident report must include:
The date and time of the incident;
Name(s) of the resident(s) involved;
Nature and extent of the abuse; person or persons involved in the abuse; and as much detail as possible describing the incident.

Seven of the 12 random staff interviewees responded appropriately to all four requirements of 115.264(a). The five remaining interviewees addressed at least three of the four requirements. Two interviewees did not address separation of the victim and perpetrator and three interviewees asserted both victim and perpetrator would be precluded from destroying physical evidence.

The auditor finds there is substantial compliance with this provision. However, it is recommended staff be reminded of all four requirements of evidence preservation as applicable to first responders.

Pursuant to the PAQ, the PD self reports all staff first responders are expected to meet the expectations of 115.264(a). The PD further self reported in 115.264(b) that there were no allegations of sexual abuse reported during the past 12 months.

There is no differentiation between security staff first responder duties and non-security staff first responders, as reflected in HPRC Policy 3.11 referenced above.

The auditor did review two documents that reflect a Coordinated Response to Sexual Assault Incidents. One document entitled HPRC Coordinated Response to PREA Incidents serves as a matrix for scripted duties. The other document entitled HPRC PREA Checklist reflects a step-by-step check off sheet to be activated in a sexual assault or abuse incident. Neither form has been used during the past 12 months however, the same serve as a constant form of staff education regarding steps to be taken in a sexual assault incident.

The auditor learned that all staff receive the same PREA training and accordingly, all staff receive the same First Responder training. Accordingly, in view of the information referenced in 115.264(a) and (b),the auditor finds substantial compliance with Standard 115.264.

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? x□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the PD self reports the facility has developed a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership.

It is noted the document is comprehensive, covering every aspect of provision 115.265(a).

HPRC Policy 3.11 entitled Coordinated Response/Staff First Response Duties, pages 1-8 provides an excellent guideline for staff use in the event of a sexual assault or sexual harassment incident at HPRC.

According to the PD, a plan is in place to coordinate actions amongst staff first responders, medical and mental health practitioners, investigators, and facility leadership in response to an incident of sexual abuse. The Coordinated Response Plan is a policy. The same is trained during PREA Annual Refresher Training.

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 x NA

115.266 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the PD self reports the facility is not engaged in any collective bargaining agreements with any entity. Accordingly, the auditor has determined HPRC is substantially compliant with 115.266.

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? x□ Yes □ No

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

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

115.267 (d)

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

115.267 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the PD self reports the agency has 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. The PD further self reports the agency designates staff member(s) or charges department(s) with monitoring for possible retaliation.

Pursuant to HPRC Policy 3.9 entitled Findings, Sanctions, and False Reporting, page, 4, section II(J)(1), the PD and Grievance Coordinator are charged with monitoring retaliation.

HPRC Policy 3.9 entitled Findings, Sanction, and False Reporting, page 4, section II(J)(1-4) addresses 115.267(a).

Pursuant to conversation with the BACS PREA Coordinator, the PD monitors both staff and resident retaliation as prescribed in this standard. The Grievance Coordinator (Deputy Director) would complete these duties in the absence of the PD.

HPRC Policy 3.9 entitled Findings, Sanctions, and False Reporting, page 4, section II(J)(2) and (4) addresses 115.267(b). This policy stipulates staff and residents who fear retaliation can speak to the mental health professional on site. Staff can also access the Company's Employee Assistance Program. Alternative protection against retaliation may include moving a resident to another housing unit or to another detention facility if deemed necessary by the Program Administrator. Additionally, HPRC staff shall monitor residents with increased security rounds, staff member contact, and visual observations when HPRC has a reasonable belief that a resident may be subject to retaliation. HPRC may utilize room reassignment or facility transfers for the purpose of protecting a resident when it has a reasonable belief that a resident may be subject to retaliation.

In addition to the above, HPRC Policy 3.10 entitled Investigations, page 2, section II(A)(1)(c) addresses this provision. This policy stipulates upon all allegations involving HPRC staff, reports shall be forwarded to the CEO of BACS for further investigation. HPRC staff who have been alleged to have engaged in sexual abuse, harassment or misconduct may be placed on administrative leave during any part of, or during the entirety of the investigative process.

The BACS CEO asserts the following in terms of strategies to protect residents and staff from retaliation for sexual abuse or sexual harassment allegations. The perpetrator would be moved to another facility/jail while investigating the allegation. If the allegation is substantiated, the perpetrator would not be returned to the facility. Victims would be monitored for retaliation for 90 days. Frequent check-ins with the victim would be employed and immediate Medical/Mental Health support would be invoked. If the victim requests, MDOC may move the victim to another facility.

Staff may be moved to ETC or vice-versa. The Shift Supervisor could be directed to increase monitoring of the victim staff member. Shift(s) or housing unit/post assignment(s) could be modified. Finally. EAP might be invoked.

In regard to the strategies available for implementation to protect residents and staff from retaliation in response to reporting sexual abuse and sexual harassment, the PD asserts there is zero tolerance for the same. A substantiated investigation of sexual abuse would result in termination of staff. Resident perpetrators would be moved to a jail while victims would be moved to other wings. We could work with Courts/Probation to facilitate early/conditional release (as appropriate) for victims. Services would be provided at either HPRC, other facilities, or through community resources.

According to the designated staff member charged with monitoring retaliation, he/she would follow-up with the victim, staff or resident, weekly for 90 days. This pertains to his/her role in preventing retaliation against residents and staff who report sexual abuse or sexual harassment or who cooperate with sexual abuse or sexual harassment allegations. Strategies to be employed with resident victims of retaliation may include resident housing changes, removal of the victim from the facility, removal of the perpetrator from the facility, change in case management, and/or invoking additional community resources. In regard to staff victims of retaliation, changing duty station (post) and/or shift, or transfer to ETC may constitute strategies to address retaliation.

When questioned as to whether he/she would initiate contact with residents who have reported sexual abuse, he/she advised contact would be initiated if he/she became aware of situation. Other than that, the PD would direct contact.

Pursuant to the PAQ, the PD self reports the facility monitors the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff. The PD further self reports the facility monitors the conduct or treatment for a period of 90 days following a report of sexual abuse. The facility acts promptly to remedy any such action. There has been no incidents of retaliation within the past 12 months.

HPRC Policy 3.9 entitled Findings, Sanctions, and False Reporting, page 4, section II(J)(3)(a-d) addresses 115.267(c). This policy stipulates the Program Administrator shall monitor the conduct or treatment of resident(s) and staff for a minimum of ninety (90) days after a report of abuse has been made. This measure is an attempt to ensure that retaliatory behavior towards those individuals is not occurring.

This includes initiating documented periodic checks, occurring at least one time weekly, with the resident, monitoring resident incident reports, housing changes, program changes, and negative performance of staff;

If it has been found that retaliation has taken place, the Program Administrator shall take action in attempt to remedy the situation;

The Program Administrator may elect to continue monitoring beyond ninety (90) days to ensure safety and security of resident and staff;

HPRC's obligation to monitor shall terminate if it determines that the allegation is unfounded.

According to the PD, the measures reflected in the narrative for 115.267(b) are implemented when retaliation is suspected. Additionally, the designated staff member charged with monitoring retaliation would reach out to the victims and initiate retaliation monitoring. He/she would reach out to Mental Health for documentation to assess retaliation. He/she would meet with the victim on a weekly basis for 90 days.

According to the staff member charged with monitoring retaliation, he/she looks for an increase or decrease in disciplinary history, isolation, staying visible so more individuals see him, if they stop showing up for meetings, increases in grievance submissions, and working more to avoid facility contact. These observations would apply to resident victims.

In regard to staff victims, an increase in write-ups, reports of other staff talking about them (lunch room talk), tardiness, avoiding residents and other staff, and documentation of every move they make (e.g. in an e-mail), are signs.

Retaliation monitoring for both staff and residents would be invoked minimally on a weekly basis for 90 days. However, resident monitoring could be invoked for the entirety of stay and as long as needed for staff. The ultimate length of monitoring would be determined by their behavior.

HPRC Policy 3.9 entitled Findings, Sanctions, and False Reporting, page 4, section II(J)(3)(a) addresses 115.267(c). The policy provision is stipulated in the narrative for 115.267(c).

HPRC Policy 3.9 entitled Findings, Sanctions, and False Reporting, page 4, section II(J)(1-3) addresses 115.267(e). Policy verbiage is articulated in the narrative for 115.267(c).

According to the BACS CEO, the same strategies he/she addressed in the narrative for 115.267(b) apply to 115.267(e).

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).] x□ 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).]
  x□ 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? x□ 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? x□ Yes □ No

- Do investigators interview alleged victims, suspected perpetrators, and witnesses?
  x□ Yes □ No

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

115.271 (f)

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

115.271 (h)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution? x□ 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? x□ 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? x□ 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).] x□ Yes □ No □ NA

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the PD self reports the facility has a policy related to criminal and administrative agency investigations.

HPRC Policy 3.10 entitled Investigations, page 1, section I addresses 115.271(a). This policy stipulates the Helena Pre-Release Center (HPRC) ensures that all reports of sexual abuse and sexual harassment are investigated promptly, thoroughly, and objectively, regardless of the source, and notifies all victims and other reporters in writing of outcomes of the investigation and sanctions imposed.

The auditor reviewed the single administrative sexual harassment investigation conducted during the last 12 months. Staff first became aware of the alleged incident during the course of an administrative disciplinary hearing (for the alleged victim) conducted on August 23, 2017. The administrative disciplinary hearing focused on an incident unrelated to the alleged sexual harassment.

The PREA Investigator became aware of the alleged incident late on August 23, 2017 and as the alleged victim was housed at a county jail for the previously referenced infraction, he was determined to be in a safe place as the alleged perpetrator was still housed at HPRC. Accordingly, the PREA Investigator commenced the administrative investigation on August 24, 2017.

As another HPRC employee had a good relationship with the alleged victim, she interviewed him at the county jail. While the alleged victim had named the alleged perpetrator, he refused to cite specific facts in terms of date(s) and time(s) of the alleged incident(s). Pursuant to review of file materials, the PREA Investigator was able to make a few fact findings in terms of the alleged victim and alleged perpetrator being confined at the same facility on a couple occasions however, given the lack of facts cited regarding incident(s) allegedly occurring at HPRC, meaningful investigation was inhibited. Accordingly, the PREA Investigator concluded that the investigation was "unsubstantiated".

It is noted the PD contacted staff at the county jail at which the alleged victim was housed and provided them with notice regarding the alleged victim's allegations. He also discussed the provision of mental health services as part of "retaliation monitoring", although the same could not be provided by HPRC staff, given the alleged victim's location at the county jail.

It is noted the PREA Investigator concluded the investigation on August 24, 2017 and the PD authored a "reporting memo" to the alleged victim regarding investigative findings, dated the same date.

Given the above, HPRC is clearly compliant with 115.271. It is also noted that retaliation monitoring was implemented with the alleged perpetrator, although not required by standard.

According to the two investigative interviewees, investigations are ordinarily initiated within 30 minutes to an hour of the time of report. Both interviewees also assert all allegations of sexual abuse and sexual harassment (including those from third-party and anonymous sources) are reported directly to facility investigators. Such allegations are treated as any other allegation, with no disparity.

While the investigation addressed above was initiated outside the stated norm in terms of timing, the auditor finds the decision to be reasonable given the afore-described circumstances and facts. The alleged victim and perpetrator were housed at separate facilities and there was no immediacy to initiate the investigation. Actually. some investigative actions were implemented with the documentation of the alleged victim's statement.

The auditor finds HPRC is substantially compliant with 115.271(a).

HPRC Policy 3.10 entitled Investigations, page 1, section II(A) addresses 115.271(b). This policy stipulates HPRC shall use investigators that have received specialized training in handling sexual abuse and sexual harassment cases. HPRC will use the Program Administrator or Security Supervisor for administrative cases.

PREA investigative training is described in detail in the narrative for 115.234(a). The primary PREA investigators at HPRC have completed training above and beyond the Basic course.

HPRC Policy 3.10 entitled Investigations, page 2, section II(C)(3) addresses 115.271(c). This policy stipulates HPRC ensures that all preserved direct and circumstantial evidence, including physical evidence, electronic monitoring data, interviews of alleged victims, suspected perpetrators and witnesses, and prior complaints regarding the alleged perpetrator, is reviewed.

According to the investigative interviewees, first investigative steps would include interview with the victim/perpetrator/witnesses/staff consuming approximately 2-3 hours dependent upon events and circumstances. Check to ensure the crime scene is secure and photograph same, consuming approximately five minutes. Collect files and data, consuming approximately 10 minutes. Review physical evidence and camera surveillance, consuming approximately one to two hours.

The investigative process would include initiation of a facility lock down. Interview victim(s), perpetrator(s), witness(es), and staff dependent upon events and circumstances. Check to ensure the crime scene is secure and photographed. Collect files and data. Review physical evidence and camera surveillance. Assess victim/witness credibility. Write report. Refer for criminal investigation, if warranted.

In regard to direct and circumstantial evidence, the facility PREA investigators would be responsible for gathering the same in an incident of sexual abuse. Interviewing other residents, reviewing records, reviewing camera surveillance/audio, and pulling Mental Health/Medical records comprise the same.

HPRC Policy 3.10 entitled Investigations, Page 2, section II(B) addresses 115.271(d). This policy stipulates it is the policy of BACS and HPRC to refer criminal investigations of sexual abuse to the Helena Police Department, who will further refer substantiated allegations for prosecution if warranted. BACS and HPRC do not conduct compelled interviews.

According to the investigative interviewees, compelled interviews are not facilitated at HPRC by HPRC PREA Investigators. Prosecution referral would be facilitated by HPD.

HPRC Policy 3.10 entitled Investigations, page 2, section II(C)(4) and (5) addresses 115.271(e). This policy stipulates HPRC will assess the credibility of an alleged victim, suspect, or witness on an individual basis and will not determine credibility by the person's status as resident or staff.

BACS, and HPRC will not require a resident, who alleges sexual abuse, to submit to a polygraph examination or other truth-telling device as a condition for proceeding with an investigation.

One of the investigative interviewees asserts alleged victim(s), suspect(s), and witness(es) are deemed to be credible until proven otherwise. Credibility assessments are based on how stories coincide with physical evidence and totality of circumstances. An examination of motive also ensues in any credibility assessment.

According to both interviewees, criminal investigations are not conducted by HPRC PREA investigators. Accordingly, under no circumstances would HPRC PREA investigators require a resident who alleges sexual abuse to submit to a polygraph examination or truth-telling device as a condition for proceeding with an investigation.

HPRC Policy 3.10 entitled Investigations, page 1, sections II(A)(1)(a and b) addresses 115.271(f). This policy stipulates HPRC shall include an effort to determine whether staff actions or failures to act contributed to the abuse; and
investigations shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings.

To assess and determine whether staff actions or failures to act contributed to the sexual abuse, investigative interviewees advise cameras are reviewed to determine if rounds were efficient or inefficient. Is/was the camera system operational? Additionally, interviews are heavily scrutinized to detect inconsistencies and/or accusatory information. Additionally, what did staff know or should they have known? Did staff deliberately turn a blind eye? Was there any neglect? Check training records.

Both interviewees advise that administrative investigation findings are documented in a written report. Reports include notification of reporter, recapitulation of interview notes, information regarding contact with HPD, synopsis of records, evaluation of credibility of interviewees, description and assessment of physical or circumstantial evidence, and assessment of staff negligence/intent.

HPRC Policy 3.10 entitled Investigations, page 2, section II(C)(6) addresses 115.271(g). This policy stipulates investigations are documented in written reports that include a description of the physical and testimonial evidence, the reasons behind credibility assessments of reporters, and copies of documentary evidence, where feasible.

Pursuant to interviews, it has been determined no criminal sexual abuse investigations have been conducted during the past 12 months.

Both interviewees assert criminal investigations are documented. As previously mentioned, criminal investigations are facilitated and completed by HPD. The content of the investigation would be similar to that referenced in the narrative for 115.271(f). Both interviewees would document that

they referred the case for criminal investigation. They would ask for a copy of the report, however, the investigating agency ultimately determines release of the investigation.

Pursuant to the PAQ, the PD self reports substantiated allegations of conduct that appear to be criminal are referred for prosecution. The PD further self reports there were no allegations of conduct that appear to be criminal that were referred for prosecution since August 20, 2012.

According to the investigative interviewees, they would refer sexual abuse/harassment cases for criminal investigation when there appears to be a Statutory violation. HPD refers such cases for prosecution.

Pursuant to the PAQ, the PD self reports the agency retains all written reports pertaining to the administrative or criminal investigation of alleged sexual abuse or sexual harassment for as long as the alleged abuser is incarcerated or employed by the agency, plus five years.

HPRC Policy 3.10 entitled Investigations, page 2, section II(D) addresses 115.271(i). This policy stipulates HPRC retains all written reports as long as the alleged abuser is incarcerated or employed by the agency, plus five years.

HPRC Policy 3.10 entitled Investigations, page 1, section I addresses 115.271(j). This policy stipulates investigations are carried to completion, even if the victim or reporter recants the allegation or if the alleged abuser or victim left the control or employment of the facility.

According to the investigative interviewees, sexual abuse cases would be referred to HPD. They (facility PREA investigators) would continue their administrative investigation. This pertains to situations wherein a staff member alleged to have committed sexual abuse terminates employment prior to a completed investigation into his/her conduct. In regard to the situation wherein a victim who alleges sexual abuse or sexual harassment or an alleged abuser leaves the facility prior to a completed investigation into the incident, the investigation would continue.

HPRC Policy 3.10 entitled Investigations, page 2, section II(C)(2) addresses 115.271(l). This policy stipulates HPRC cooperates with outside investigators, and endeavors to remain informed about the outside agency’s progress with the investigation.

According to the PD, in the event an outside agency investigated allegation(s) of sexual abuse, HPD investigators would stay in contact with him. Actually, he would attempt to stay in contact with HPD investigator(s) on a weekly basis. The PREA Coordinator essentially corroborates the PD's statement as he asserts there would be weekly contact between facility PREA investigator(s) and HPD investigators. As previously stated, the PD is one of the facility PREA investigators.

PREA investigative interviewees also assert, in terms of their role with outside investigators conducting a sexual abuse investigation, they would work their administrative investigation(s) in conjunction with the criminal investigation. They would work as a liaison, documenting and collecting

additional non-physical evidence, advising appropriate parties of the progress of the investigation, and checking on the status of the investigation on a weekly basis.

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? x□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the PD self reports the agency imposes a standard of preponderance of the evidence or a lower standard of proof when determining whether allegations of sexual abuse or sexual harassment are substantiated.

HPRC Policy 3.10 entitled Investigations, page 3, section II(E) addresses 115.272(a). This policy stipulates all allegations will be considered substantiated if supported by no standard higher than a preponderance of the evidence. If evidence is insufficient, the allegations will be considered unsubstantiated, but not unfounded.

One of the two PREA Investigator interviewees describes the requisite administrative preponderance of evidence as 51% probability the incident happened. The other PREA Investigator interviewee describes preponderance of the evidence required for an administrative finding as 51% while the criminal evidence requisite is 75%- 90% (beyond a reasonable doubt).

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? x□ Yes □ No

115.273 (b)

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

115.273 (e)

- Does the agency document all such notifications or attempted notifications? x□ Yes □ No

115.273 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

x☐ **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*)

Pursuant to the PAQ, the PD self reports the agency has a policy requiring that any resident who makes an allegation that he or she suffered sexual abuse in an agency facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the agency. The PD further self reports the agency completed no criminal/or administrative investigations of alleged resident sexual abuse during the past 12 months.

While no criminal/or administrative investigations of alleged sexual abuse were conducted during the past 12 months, an administrative investigation of resident-on-resident sexual harassment was conducted and the same was found to be unsubstantiated. The record reflects the PD did inform the alleged victim, in writing, of the findings.

HPRC Policy 3.10 entitled Investigations, page 3, section III(A) addresses 115.273(a). This policy stipulates following an investigation into a resident's allegation of sexual abuse/sexual harassment in the facility, the Program Administrator informs the resident of the findings-whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded.

As previously indicated, the auditor did review the investigation referenced in 115.271 and found that the PD did inform the alleged victim, in writing, that the sexual harassment investigation had been determined to be unsubstantiated. The memorandum was dated August 24, 2017.

It is noted the standard provision applies only to allegations of sexual abuse suffered in an agency facility. The HPRC addresses reporting to the alleged victim of both sexual abuse and sexual harassment. Clearly, the policy and implementation of the same exceeds standards expectations. Accordingly, the auditor finds that HPRC exceeds Standard 115.273.

According to the PD, the facility does notify a resident who makes an allegation of sexual abuse when the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation. The one investigation he completed resulted in notification of the resident victim that the investigation was "Unsubstantiated".

Both investigative interviewees assert agency procedure requires that a resident who makes an allegation of sexual abuse must be informed as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation.

Pursuant to the PAQ, the PD self reports if an outside entity conducts such investigations, the agency requests the relevant information from the investigative entity in order to inform the resident of the outcome of the investigation. As referenced in the narrative for 115.273(a), no criminal investigations of facility sexual abuse were conducted in the past 12 months. Accordingly, there were no resident notifications for sexual abuse at HPRC during the past 12 months.

HPRC Policy 3.10 entitled Investigations, page 3, section III(B) addresses 115.273(b). This policy stipulates HPRC shall request the relevant information from the Helena Police Department, or other outside agencies who may have completed the investigation, in order to inform the resident.

Pursuant to the PAQ, the PD self reports following a resident's allegation that a staff member has committed sexual abuse against the resident, the agency/facility subsequently informs the resident (unless the agency has determined that the allegation is unfounded) whenever:
• The staff member is no longer posted within the resident's unit;
• The staff member is no longer employed at the facility;
• The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or
• The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility.
The PD further self reports there has been no substantiated or unsubstantiated complaint(s) (i.e., not unfounded) of sexual abuse committed by a staff member against a resident in an agency facility in the past 12 months.

HPRC Policy 3.10 entitled Investigations, page 3, section III(C)(1-4) addresses 115.273(c). This policy stipulates following a resident's allegation of sexual abuse by a staff member, HPRC informs the resident (unless the allegation is unfounded) whenever:
The staff member is no longer assigned to the resident's unit;
The staff member is no longer employed at the facility;
HPRC learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or
HPRC learns that the staff member has been convicted on a charge related to sexual abuse within the facility.

Pursuant to the PAQ, the PD self reports following a resident's allegation that he or she has been sexually abused by another resident in an agency facility, the agency subsequently informs the alleged victim whenever:
• The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or
• The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility.

HPRC Policy 3.10 entitled Investigations, page 3, section III(D)(1 and 2) addresses 115.273(d). This policy stipulates following a resident's allegation of sexual abuse by another resident HPRC shall subsequently inform the alleged victim whenever:
HPRC learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or
HPRC learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility.

As there are no residents who reported a sexual abuse currently housed at HPRC, that interview could not be completed. Additionally, the record reflects there were no sexual abuse allegations at HPRC during the past 12 months.

Pursuant to the PAQ, the PD self reports the agency has a policy that all notifications to residents described under this standard are documented. As previously indicated no allegations of sexual abuse have been reported at HPRC during the past 12 months.

HPRC Policy 3.10 entitled Investigations, page 4, section III(E) addresses 115.273(e). This policy stipulates all such notifications or attempted notifications shall be documented. This provision references the notification identified in the preceding narratives for 115.273(c) and (d).

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? x□ Yes □ No

115.276 (b)

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the PD self reports staff is subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

HPRC Policy 3.9 entitled Findings, Sanctions, and False Reporting, page 3, section II(H) addresses 115.276(a). This policy stipulates HPRC staff shall be subject to disciplinary sanctions up to and including termination for violating HPRC sexual abuse or sexual harassment policies.

Pursuant to the PAQ, the PD self reports zero facility staff violated agency sexual abuse or sexual harassment policies.

HPRC Policy 3.9 entitled Findings, Sanctions, and False Reporting, page 3, section II(H)(1) addresses 115.276(b). This policy stipulates termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse.

Pursuant to the PAQ, the PD self reports disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are 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. The PD further self reports in the past 12 months, zero staff from the facility have been disciplined, short of termination, for violation of agency sexual abuse or sexual harassment policies.

HPRC Policy 3.9 entitled Findings, Sanctions, and False Reporting, page 3, section II(H)(2) addresses 115.276(c). This policy stipulates disciplinary sanctions for violations of HPRC policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) shall be 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.

Pursuant to the PAQ, the PD self reports 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, are reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. The PD further self reports in the past 12 months, no facility staff have been reported to law enforcement or licensing boards following their termination (or resignation prior to termination) for violating agency sexual abuse or sexual harassment policies.

HPRC Policy 3.9 entitled Findings, Sanctions, and False Reporting, page 3, section II(H)(3) addresses 115.276(d). This policy stipulates all terminations for violations of HPRC sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to the Helena Police Department, unless the activity was clearly not criminal, and to any relevant licensing bodies.

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? x□ Yes □ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies unless the activity was clearly not criminal? x□ Yes □ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? x□ 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? x□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the PD self reports agency policy requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies, unless the activity was clearly not

criminal, and to relevant licensing bodies. The PD further self reports agency policy requires that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents.

In the past 12 months, no contractors or volunteers were reported to law enforcement agencies and relevant licensing bodies for engaging in sexual abuse of residents. The PD further asserts there were no allegations of sexual abuse lodged against contractors or volunteers during the past 12 months.

HPRC Policy 3.9 entitled Findings, Sanctions, and False Reporting, page 3, section II(I)(1) addresses 115.277(a). This policy stipulates any contractor or volunteer who engages in sexual abuse/sexual harassment shall be prohibited from contact with residents and shall be reported to the Helena Police Department, unless the activity was clearly not criminal, and to relevant licensing bodies.

Given the above, the auditor finds HPRC to be compliant with 115.277(a).

Pursuant to the PAQ, the PD self reports the facility takes appropriate remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

HPRC Policy 3.9 entitled Findings, Sanctions, and False Reporting, page 3, section II(I)(2) addresses 115.277(b). This policy stipulates HPRC shall take appropriate remedial measures, and shall consider whether to prohibit further contact with residents, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

According to the PD, in the case of any violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, privileges would be temporarily rescinded pending the outcome of an investigation.

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? x□ 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? x□ 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? x□ 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 x NA

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? x□ 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? x□ Yes □ No

115.278 (g)

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the PD self reports residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse. The PD further self reports residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following a criminal finding of guilt for resident-on-resident sexual abuse.

According to the PD, there were no substantiated administrative findings of resident-on-resident sexual abuse that occurred at the facility during the past 12 months. The PD further self reports there were no substantiated criminal findings of resident-on-resident sexual abuse that occurred at the facility during the past 12 months.

HPRC Policy 3.9 entitled Findings, Sanctions, and False Reporting, page 2, section II(C) addresses 115.278(a). This policy stipulates an administrative finding that the resident engaged in sexual abuse/sexual harassment, or following a criminal investigation that has substantiated offender-on-offender sexual abuse/sexual harassment, shall be subject to a formal disciplinary process. The disciplinary sanctions shall take into consideration the following:
Nature and circumstances of the abuse committed;
Resident's disciplinary history;
Sanctions imposed for comparable offenses by other residents with similar histories.

HPRC Policy 3.9 entitled Findings, Sanctions, and False Reporting, page 2, section II(C)(1-3) addresses 115.278(b). The policy provisions are articulated in the narrative for 115.278(a).

According to the PD, disciplinary sanctions available for residents following an administrative or criminal finding that the resident engaged in resident-on-resident sexual abuse are transfer to a secure facility, imposition of new criminal charges, and discharge from the HPRC program. MDOC would actually make determinations regarding placement, etc. in consideration of the PD's recommendations. Disciplinary hearings are handled by MDOC.

The auditor reviewed the MDOC policy regarding the conduct of resident administrative disciplinary proceedings and while not specifically articulated in the same, some factors regarding assessment of mental disability or mental illness in terms of the imposition of sanctions, appear to be covered.

The auditor has determined MDOC staff conduct administrative misconduct hearings pursuant to contract with HPRC. Accordingly, HPRC plays a minimal role in terms of the conduct of the hearings.

MDOC policy has been provided regarding assessment of whether the resident's mental disabilities or mental illness contributed to his or her behavior (when determining the type of sanction, if any, should be imposed), and the following generically addresses the issue:

P&P Policy 140-1, page 10 stipulates before making any decision, the Hearing Officer should be informed of the offender's
• criminal history background;
• treatment history;
• whether the offender is a DOC or MSP commitment;
• conditions of sentence;
• Previous behavior in the PRC;
• Previous programming such as TSCTC; Connections Corrections; PRC; ISP etc.;
• Length of time the offender has been in the program; and
• Time until discharge or parole.

In view of the above, the auditor finds that 115.278(c) is not applicable to HPRC, given the above discussion. Rather, by contract and actual practice, MDOC staff are responsible for making the requisite determination(s).

Pursuant to the PAQ, the PD self reports the facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse. The PD further self reports if the facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse, the facility considers whether to require the offending resident to participate in such interventions as a condition of access to programming or other benefits.

HPRC Policy 3.9 entitled Findings, Sanctions, and False Reporting, page 2, section II(D)(1-3) addresses 115.278(d). This policy stipulates when determining the type of sanction, if any, to be imposed, the Program Administrator:
Shall consider whether or not a resident's mental disabilities or mental illness contributed to their behavior;
May offer therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse;
May consider whether to require the offending resident to participate in these interventions as a condition of access to any type of behavior based programming, but not to general programming or education.

According to the Mental Health interviewee, it would be considered whether to offer therapy, counseling, or other intervention services designed to address and correct the underlying reasons or motivations for sexual abuse, to offending resident(s). Therapies and treatment may include one-on-one counseling, group therapy, and/or community referrals. Additionally, consideration as to whether participation is required as a condition of access to programming or other benefits, would ensue.

As previously indicated, the perpetrator of sexual abuse would, more than likely, be moved to a secure facility by virtue of PD recommendation and MDOC decision. Accordingly, the auditor finds the majority of this provision to be contingent upon the decision-making process with MDOC and, more than likely, not applicable to HPRC.

Pursuant to the PAQ, the PD self reports the agency disciplines residents for sexual conduct with staff only upon finding that the staff member did not consent to such contact.

HPRC Policy 3.9 entitled Findings, Sanctions, and False Reporting, page 3, section II(G) addresses 115.278(e). This policy stipulates HPRC may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact.

Pursuant to the PAQ, the PD self reports the agency prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation.

HPRC Policy 3.9 entitled Findings, Sanctions, and False Reporting, page 2, section II(E) addresses 115.278(f). This policy stipulates for the purpose of disciplinary action, a report of sexual abuse/ sexual harassment made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.

Pursuant to the PAQ, the PD self reports the agency prohibits all sexual activity between residents. The PD further self reports if the agency prohibits all sexual activity between residents and disciplines residents for such activity, the agency deems such activity to constitute sexual abuse only if it determines that the activity is coerced.

HPRC Policy 3.9 entitled Findings, Sanctions, and False Reporting, pages 2 and 3, section II(F) addresses 115.278(g). This policy stipulates HPRC prohibits all sexual activity between residents and disciplines residents for such activity with a Class II violation of inappropriate misconduct. HPRC does not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced.

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?
  x□ 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? x□ Yes □ No

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the PD self reports resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The PD further self reports the nature and scope of such services are determined by medical and mental health practitioners according to their professional judgment. Additionally, medical and mental health staff maintain secondary materials (e.g., forms, logs) documenting the timeliness of emergency medical treatment and crisis intervention services that were provided; the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; and the provision of appropriate and timely information and services concerning contraception and sexually transmitted infection prophylaxis.

As there were no sexual abuse incidents invoking such medical procedures during the past 12 months, no completed documents were reviewed. However, the auditor reviewed documents that would be completed in the event of a sexual abuse incident. Specifically, an HPRC PREA Response Checklist Medical Response form reflects times and dates of implementation of certain medical steps within the response context. The document also references the incident by case number, resident name, location of the incident. Specific medical services and treatment would be maintained in the affected resident's medical file.

According to both the medical and mental health interviewees, resident victims of sexual abuse receive timely and unimpeded access to emergency medical treatment and crisis intervention services. Both interviewees further assert such services are rendered almost immediately. The nature and scope of these services would be initially determined according to their professional judgment if summoned to the facility however, if transferred to a hospital, medical judgment becomes the purview of hospital provider(s).

HPRC Policy 3.11 entitled Coordinated Response/Staff First Response Duties, pages 1 and 2, section II(A)(1)(a-m) addresses 115.282(b). This policy stipulates the first staff member responding at an allegation of sexual abuse must:
Physically separate the alleged victim from the alleged abuser;
Notify all necessary staff (immediate supervisor, administrator, medical, mental health) of HPRC;
Address the need for acute medical treatment and contact community medical (hospital) personnel if needed;
Follow universal precautions for bodily fluids;
Ensure a staff member stays with the alleged victim until the alleged victim is placed in the care of another staff member such as mental health or medical personnel;
Preserve and protect any potential crime scene until law enforcement arrives;
Escort residents to "dry" areas where water may not be accessed, ensuring sight and sound separation of alleged victim and alleged abuser;
If the alleged abuse occurred within 96 hours, first responder staff shall immediately request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, drinking, or eating;
Refrain from asking alleged victim detailed questions about the incident to avoid possible traumatization;
If the abuse occurred within 72 hours, first responder staff shall immediately ensure that the alleged perpetrator not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating.
Ensure pictures are taken of any scratches, abrasions, wounds, or other visible signs of injury except in cases where the injury is to the genitals or breasts;
One security staff member is to supervise each resident (alleged victim and alleged offender). One staff member or mental health staff member will stay with alleged victim until alleged victim is placed in the care of another staff member via directive of supervision of security staff or administrator;
Consult with Supervisor and complete the necessary significant incident report. This incident report must include:
The date and time of the incident;
Name of the residents or residents involved;
Nature and extent of the abuse; person or persons involved in the abuse; and as much detail as possible describing the incident.

The PREA Checklist completed by the shift supervisor serves as a platform for documentation of date(s) and time(s) for each step of the incident time line, inclusive of medical.

Seven of the 12 random staff interviewees responded appropriately to all four requirements of 115.262. The five remaining interviewees addressed at least three of the four requirements. Two interviewees did not address separation of the victim and perpetrator and three interviewees asserted both victim and perpetrator would be precluded from destroying physical evidence.

The auditor finds there is substantial compliance with this provision. However, it is recommended staff be reminded of all four requirements of evidence preservation as applicable to first responders.

Pursuant to the PAQ, the PD self reports resident victims of sexual abuse while incarcerated are 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. The PD further self reports medical and mental health staff maintain secondary materials (e.g., forms, logs) documenting the timelines of emergency medical treatment and crisis intervention services that were provided; the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; and the provision of appropriate and timely information and services concerning contraception and sexually transmitted infection prophylaxis.

The medical staff interviewee asserts victims of sexual abuse are offered timely information about access to emergency contraception and sexually transmitted infection prophylaxis. The medical interviewee asserts she would provide information to hospital providers to aid in this process.

Pursuant to the PAQ, the PD self reports treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

HPRC Policy 3.5 entitled Medical and Mental Health, page 3, section II(C)(3) addresses 115.282(d). This policy stipulates treatment services, and all necessary testing, shall be provided to victims of sexual abuse without financial cost, regardless of whether the victim names the abuser, and regardless of whether or not the victim cooperates with any investigation arising from initial report of the incident.

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? x□ 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? x□ Yes □ No

115.283 (c)

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

115.283 (d)

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

115.283 (e)

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

115.283 (f)

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the PD self reports the facility offers 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.

HPRC Policy 3.5 entitled Medical and Mental Health, pages 2 and 3, section II(C)and (1) addresses 115.283(a). This policy stipulates HPRC will offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, or lockup. HPRC will offer a medical and mental health evaluation, at no financial cost, and if appropriate, treat-

ment to all residents who have been victimized by sexual abuse in any community corrections facility, juvenile facility, jail or lockup.

HPRC Policy 3.5 entitled Medical and Mental Health, page 3, section II(C)(1) addresses 115.283(b). This policy stipulates HPRC will offer a medical and mental health evaluation, at no financial cost, and if appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, community corrections facility, juvenile facility, jail or lockup. The mental health and medical health professionals will need to ensure that when the victim is released or transferred from the facility to another facility, or released from custody that there are follow-up services, treatment plans, and referrals for continued mental and medical healthcare.

According to the medical staff interviewee, evaluation and treatment of residents who have been victimized would entail triage of the patient. If bleeding/bruising is noted, stabilize them. Call for the ambulance, if warranted. Bag items removed by the resident. Remain with the victim.

The mental health interviewee asserts she would determine what happened in the event. Assess family systems issues, mental health condition(s), and educational history. She would primarily provide support and empathy.

HPRC Policy 3.5 entitled Medical and Mental Health, page 3, section II(C)(2) addresses 115.283(c). This policy stipulates HPRC shall provide such victims with medical and mental health services consistent with the community level of care.

Both medical and mental health staff interviewees advise care would be provided consistent with the community level of care. As noted throughout the medical/mental health provisions in this report, initial care, as described in the narrative for 115.283(b) may be provided by HPRC medical staff if time allows for them to report to the facility. At any rate, care would be transferred to a community hospital for SAFE/SANE examination and any follow-up care.

The auditor finds HPRC to be substantially compliant with this provision.

HPRC is a male only facility and accordingly, the auditor has determined that 115.283(d), and (e) are not applicable to HPRC.

Pursuant to the PAQ, the PD self reports resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate.

HPRC Policy 3.5 entitled Medical and Mental Health, page 3, section II(C)(4) addresses 115.283(f). This policy stipulates timely access to sexually transmitted infection prophylaxis, general information, and forensic exams will be available, at no financial cost, for any resident victim of sexual abuse while incarcerated as medically appropriate.

Pursuant to the PAQ, the PD self reports treatment services are provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

HPRC Policy 3.5 entitled Medical and Mental Health, page 3, section II(C)(4) addresses 115.283(g). This policy stipulates treatment services, and all necessary testing, shall be provided to victims of sexual

abuse without financial cost, regardless of whether the victim names the abuser, and regardless of whether or not the victim cooperates with any investigation arising from initial report of the incident.

As reflected throughout this report, there has been no allegations of sexual abuse at HPRC during the past 12 months. No residents who reported a sexual abuse were housed at HPRC during the on-site audit. Accordingly, an interview of residents who reported a sexual abuse was not conducted.

Pursuant to the PAQ, the PD self reports the facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history, and offers treatment when deemed appropriate by mental health practitioners.

HPRC Policy 3.5 entitled Medical and Mental Health, page 3, section II(C)(5) addresses 115.283(h). This policy stipulates HPRC will contact a mental health professional to conduct a mental health evaluation of all known offender-on-offender abusers within sixty (60) days of learning of such abuse history, and offer treatment when deemed appropriate by mental health practitioners.

The mental health staff interviewee asserts she reviews all incoming psychology files. If a sexual abuser is detected, she conducts an assessment. Case Managers can also refer residents for assessment.

During the course of resident interviews, the auditor learned that one of the interviewees was a resident-on-resident abuser at another facility. During follow-up conversation with the PD, it was learned he had received information about the resident and he followed up with mental health regarding the matter. An evaluation had been conducted and was properly documented.

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? x□ Yes □ No

115.286 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? x□ 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? x□ 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? x□ 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? x□ 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? x□ Yes □ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? x□ Yes □ No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? x□ 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? x□ Yes □ No

115.286 (e)

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

Auditor Overall Compliance Determination

x☐ **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*)

Pursuant to the PAQ, the PD self reports the facility conducts a sexual abuse incident review at the conclusion of every criminal or administrative sexual abuse investigation, unless the allegation has been determined to be unfounded. The PD further self reports in the past 12 months, no criminal and/or administrative investigations of alleged sexual abuse were completed at the facility, excluding only “unfounded” incidents.

HPRC Policy 3.7 entitled Data Collection, Aggregation, and Review, page 1, section II(A)(1)(a) addresses 115.286(a). This policy stipulates HPRC shall conduct a sexual abuse incident review at the conclusion of every criminal or administrative sexual abuse or sexual harassment investigation including whether the allegation has not been substantiated, unless the allegation has been determined to be unfounded. The review will include all members of the Sexual Assault Review Team (SART).

The auditor reviewed the HPRC SART Checklist regarding the "Unsubstantiated" sexual harassment investigation completed on August 24, 2017. This investigation was elaborated upon in 115.271. The auditor finds the SART Review was conducted commensurate with all provisions of 115.286.

Given the fact 115.286(a) addresses the conduct of SART reviews at the conclusion of every sexual abuse investigation, unless the allegation is determined to be "Unfounded", the auditor finds HPRC exceeds the provision and standard by virtue of policy and practice. Specifically, the afore-mentioned policy also requires the conduct of a SART review in the case of a "Substantiated" or "Unsubstantiated" sexual harassment investigation. The completed SART review in this matter and accompanying recommendation signifies the commitment of BACS and HPRC to the enhancement of sexual safety at the facility.

Pursuant to the PAQ, the PD self reports the facility ordinarily conducts a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation. The PD further self reports in the past 12 months, no criminal and/or administrative investigations of alleged sexual abuse were completed at HPRC and accordingly, there were no SART reviews that followed within 30 days.

HPRC Policy 3.7 entitled Data Collection, Aggregation, and Review, page 1, section II(A)(1)(b) addresses 115.286(b). This policy stipulates such review shall occur within 30 days of the conclusion of the investigation.

The afore-referenced investigation was concluded on August 24, 2017 and the SART review was completed on August 30, 2017.

Pursuant to the PAQ, the PD self reports the sexual abuse incident review team includes upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners.

HPRC Policy 3.7 entitled Data Collection, Aggregation, and Review, page 1, section II(A)(1)(c) addresses 115.286(c). This policy stipulates the SART team includes the following; PREA Manager, Program Administrator, Security Supervisor, Mental Health, Nurse, Shift Supervisor, and PREA Investigators.

Pursuant to the PD's interview, the auditor learned the afore-mentioned policy provides the total of the SART Review team. It may not be possible to assemble all players, as identified, for each review.

Pursuant to the auditor's review, the afore-mentioned SART review participants were the PD/PREA Manager, Mental Health and Medical representatives, alleged victim's Case Manager, HPRC Deputy Director, and Security Supervisor. The auditor finds the same to be commensurate with both HPRC policy and this provision.

The PD further related during his interview that HPRC does have a sexual abuse incident review team. The same does include the composition of staff as required in policy, with the exception noted above.

Pursuant to the PAQ, the PD self reports the facility prepares a report of its findings from sexual abuse incident reviews, including but not necessarily limited to, determinations made pursuant to the following considerations:

(1) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse;
(2) 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;
(3) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;
(4) Assess the adequacy of staffing levels in that area during different shifts;
(5) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff and any recommendations for improvement, and submits such report to the facility head and PREA Coordinator.

HPRC Policy 3.7 entitled Data Collection, Aggregation, and Review, page 2, section II(A)(1)(d) addresses 115.286(d). This policy stipulates the review team shall: (1) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; (2) 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; (3) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; (4) Assess the adequacy of staffing levels in that area during different shifts; (5) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and (6) Prepare a report of its findings, including but not necessarily limited to determinations made, and any recommendations for improvement, and submit such report to the PREA Coordinator for review. The HPRC Program Administrator will be involved in the initial review process as part of the SART team.

The afore-mentioned HPRC SART Checklist addresses all of the requisite components of 115.286(d) and the same were adequately addressed with known facts and observations.

According to the PD, the SART considers staffing plan viability, camera placements, and assesses whether improvements (policy, procedure, training) are warranted. In a separate conversation, the PD stated the SART is used to enhance the PREA program and sexual safety at HPRC.

The PD also stated the SART: (1) Considers whether the incident or allegation was motivated by race, ethnicity, gender identity, lesbian/gay/bisexual/transgender/intersex identification, status, or

perceived status, or gang affiliation, or was motivated or otherwise caused by other group dynamics at the facility; (2) Examines the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; (3) Assesses the adequacy of staffing levels in that area during different shifts; and (4) Assesses whether monitoring technology should be deployed or augmented to supplement supervision by staff. The SART interviewee also confirmed these issues are considered during the SART review.

The PREA Coordinator advises that a report is prepared of SART findings including any determinations regarding the factors previously identified in this provision. The reports are forwarded to the PREA Coordinator however, he/she is often times involved in SART reviews. No trends have been identified. If deficiencies are identified subsequent to the PREA Coordinator's review or participation in the SART, he/she makes recommendations and discusses the same with the BACS CEO.

Pursuant to the PAQ, the PD self reports the facility implements the recommendations for improvement or documents its reasons for not doing so.

HPRC Policy 3.7 entitled Data Collection, Aggregation, and Review, page 2, section II(A)(1)(e) addresses 115.286(e). This policy stipulates HPRC will implement the recommendations for improvement, or shall document its reasons for not doing so.

With respect to the afore-mentioned HPRC SART Checklist, no recommendations were identified given the scarcity of facts provided by the alleged victim.

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? x□ Yes □ No

115.287 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually? x□ 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? x□ 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?
  x□ 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 x□ 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 x□ NA

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the PD self reports the agency collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. The PD further self reports the standardized instrument includes, 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.

HPRC Policy 3.7 entitled Data Collection, Aggregation, and Review, pages 2 and 3, section II(A)(2)(a-k) addresses 115.287(a)/(c). This policy stipulates HPRC shall collect accurate, uniform data for every allegation of sexual abuse and sexual harassment using the standardized instrument known as the Survey of Sexual Violence (SSV) and it will be collected annually. If the SSV data collection is not conducted by the Bureau of Justice Statistics, the following data shall be collected:
The number of incidents that met the definition of sexual abuse and sexual harassment as outlined in the PREA Standards;
The area where the incident occurred;
The time of the incident;
The victim's age, ethnicity, and gender;
The type of abuse or injury;
How the incident was reported;
If the incident was resident on resident, staff on resident, or resident on staff;
The perpetrators age, ethnicity, and gender;
The nature of the incident; and
Sanctions imposed on the perpetrator.

The auditor reviewed two statistical compilation documents entitled 2016 PREA Data and 2016 Annual PREA Statistical Report, finding the same to meet the majority of criteria required by this provision.

In addition to the above, the auditor reviewed the 2014, 2015, and 2016 SSVs for HPRC.

Pursuant to the PAQ, the PD self reports the agency aggregates the incident-based sexual abuse data at least annually.

HPRC Policy 3.7 entitled Data Collection, Aggregation, and Review, page 3, section II(A)(6) addresses 115.287(b). This policy stipulates all aggregated sexual abuse/sexual harassment data, shall be made readily available to the public at least annually through HPRC's website located at (www.boydandrew.com).

The auditor verified that the afore-mentioned statistical compilation documents do reflect annual aggregation, although this audit is an Initial PREA Audit.

Pursuant to the PAQ, the PD self reports the agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

HPRC Policy 3.7 entitled Data Collection, Aggregation, and Review, page 3, section II(A)(3) addresses 115.287(d). This policy stipulates the data shall be collected, reviewed and maintained on an ongoing basis as needed from all available incident-based documents, including reports, investigation files, and sexual abuse/sexual harassment incident reviews.

Pursuant to the PAQ, the PD self reports HPRC does not contract for confinement of its residents. Accordingly, the auditor has determined 115.287(e) is not applicable to HPRC.

Pursuant to the PAQ, the PD self reports the agency has not provided the Department of Justice with data from the previous calendar year as the same has not been requested. Accordingly, the auditor finds 115.287(f) to be not applicable to HPRC.

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? x□ 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?
  x□ 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? x□ 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 x□ 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? x□ 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? x□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the PD self reports the agency reviews data collected and aggregated pursuant to 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, and training, including:
• Identifying problem areas;
• Taking corrective action on an ongoing basis; and
• Preparing an annual report of its findings from its data review and any corrective actions for each facility, as well as the agency as a whole.

HPRC Policy 3.7 entitled Data Collection, Aggregation, and Review, page 3, section II(B)(1)(a-c) addresses 115.288(a). This policy stipulates HPRC shall review data collected and aggregated pursuant to this section in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including:
Identifying problem areas;

Taking corrective action; and
Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole.

The auditor reviewed the HPRC Annual Report which compares data from 2014 through 2016 with a recapitulation of findings with respect to investigations by year. Additionally, the Annual Report addresses the Annual Staffing Plan, camera surveillance, policies, and training endeavors. For purposes of this Initial PREA Audit, the PREA Annual Report is sufficient as the same does capture facility efforts to enhance sexual safety at HPRC.

According to the CEO, incident-based sexual abuse data is used to assess and improve sexual abuse prevention, detection, and response policies, practices, and training through review of annual reports, assessing patterns, assessing camera surveillance, and assessing staffing needs. This provides a guideline to enhancing resident sexual safety at HPRC.

According to the PREA Coordinator, he does review data collected and aggregated pursuant to 115.287 in order to assess and improve the effectiveness of HPRC's sexual abuse prevention, detection, and response policies, and training. His primary role in the process includes collection of aggregated data, identification of trends, and making changes in training, policy, and/or staffing. This data is stored and locked in a file cabinet in the PREA Coordinator's office. Corrective action with respect to review of such data has not yet been required however, BACS and HPRC response to any needs identified would be implementation of immediate corrective action.

The PREA Coordinator asserts annual reports are generated from each individual facility.

It is noted the auditor did observe the afore-mentioned locked file cabinet in the PREA Coordinator's Office throughout the on-site review.

Pursuant to the PAQ, the PD self reports the annual report includes a comparison of the current year’s data and corrective actions with those from prior years. The PD further self reports the annual report provides an assessment of the agency’s progress in addressing sexual abuse.

The auditor finds the HPRC Annual Report to be compliant with 115.288(b).

Pursuant to the PAQ, the PD self reports the agency makes its annual report readily available to the public at least annually through its website. The PD further self reports the annual reports are approved by the agency head.

Pursuant to the auditor's review of the HPRC Annual Report, the PREA Coordinator, Chief Operating Officer, BACS, and Chief Executive Officer, BACS signed the same. Additionally, the auditor notes the Annual Report is posted on the BACS website.

The BACS CEO asserts she does approve annual reports written pursuant to this standard.

Pursuant to the PAQ, the PD self reports 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. The PD further self reports the agency indicates the nature of material redacted.

HPRC Policy 3.7 entitled Data Collection, Aggregation, and Review, page 4, section II(B)(4) addresses 115.288(d). This policy stipulates HPRC may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of HPRC, but must indicate the nature of the material redacted.

The auditor did not find any evidence of redaction in the HPRC Annual Report.

The PREA Coordinator asserts any personal identifiers or sensitive security/safety information would be redacted from the Annual Report. It would be practice to indicate the nature of the material redacted from the report.

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? x□ 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? x□ Yes □ No

115.289 (c)

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the PD self reports the agency ensures incident-based and aggregate data are securely retained.

HPRC Policy 3.7 entitled Data Collection, Aggregation, and Review, page 4, section II(C)(1) addresses 115.289(a). This policy stipulates HPRC shall ensure that data collected pursuant to 115.287 are securely retained. Data will be securely maintained with the Program Administrator or PREA Coordinator.

Pursuant to the PAQ, the PD self reports agency policy requires that aggregated sexual abuse data from facilities under its direct control and private facilities with which it contracts is made readily available to the public, at least annually, through its website.

HPRC Policy 3.7 entitled Data Collection, Aggregation, and Review, page 4, section II(C)(2) addresses 115.289(b). This policy stipulates HPRC shall make all aggregated sexual abuse/sexual harassment data, readily available to the public at least annually through its website.

The auditor reviewed the BACS/HPRC website and validated the requisite information is maintained therein.

Pursuant to the PAQ, the PD self reports before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers.

HPRC Policy 3.7 entitled Data Collection, Aggregation, and Review, page 4, section II(C)(3) addresses 115.289(c). This policy stipulates before making aggregated sexual abuse/sexual harassment data publicly available, HPRC shall remove all personal identifiers.

The auditor reviewed all aggregated data reflected on the afore-mentioned website and found no issues relative to identifiers being included in any data.

Pursuant to the PAQ, the PD self reports the agency maintains sexual abuse data collected pursuant to 115.287 for at least 10 years after the date of initial collection, unless federal, state, or local law requires otherwise.

HPRC Policy 3.7 entitled Data Collection, Aggregation, and Review, page 4, section II(C)(4) addresses 115.289(d). This policy stipulates HPRC shall maintain sexual abuse/sexual harassment 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.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

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

115.401 (a)

- During the three-year period starting on August 20, 2013, and during each three-year period thereafter, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once.? (N/A before August 20, 2016.) □ Yes □ No x□ NA

115.401 (b)

- During each one-year period starting on August 20, 2013, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited? □ Yes □ No x NA

115.401 (h)

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

115.401 (i)

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

115.401 (m)

- Was the auditor permitted to conduct private interviews with inmates, residents, and detainees? x□ 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? x□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

The BACS PREA Coordinator was very facilitative in terms of assembly of PAQ materials. As the auditor identified questions and required additional information, the PREA Coordinator provided the same in expeditious fashion. Facility staff were very transparent and attentive to the auditor's needs.

Interview accommodations at the facility were exceptional. The PREA Coordinator ensured that randomly selected interviewees arrived in expeditious fashion, thereby facilitating an effective interview process. All interviews were conducted in a private and confidential setting.

PREA Audit Notices were generously posted throughout the facility. Both residents and staff were generally aware of the audit and PREA standards.

Standard 115.403: Audit contents and findings

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

115.403 (f)

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

x NA

This is an Initial Audit and accordingly, no Final Audits have been issued in the past three years.

AUDITOR CERTIFICATION

I certify that:

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

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

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

Auditor Instructions:

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

K. E. Arnold **02/28/2018**

Auditor Signature **Date**

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

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