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

☐ **Interim** X☐ **Final**

Date of Interim Audit Report: October 28, 2020 ☐ **N/A**
Date of Final Audit Report: March 23, 2021

Auditor Information

Name: K. E. Arnold	**Email:** kenarnold220@gmail.com
Company Name: KEA Correctional Consulting LLC	
Mailing Address: P. O. Box 1872	**City, State, Zip:** Castle Rock, CO 80104
Telephone: 484-999-4167	**Date of Facility Visit:** September 8-9, 2020

Agency Information

Name of Agency: Boyd Andrew Community Services			
Governing Authority or Parent Agency *(If Applicable)*: NA			
Physical Address: 60 S. Last Chance Gulch		**City, State, Zip:** Helena MT 59601	
Mailing Address: PO Box 1153		**City, State, Zip:** Helena MT 59624	
The Agency Is:	☐ Military	☐ Private for Profit	X☐ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal
Agency Website with PREA Information: https://www.boydandrew.com			

Agency Chief Executive Officer

Name: Amy Tenney	
Email: atenney@boydandew.com	**Telephone:** 406-442-6572 ex 2006

Agency-Wide PREA Coordinator

Name: Madisen Lindquist	
Email: mlindquist@boydandrew.com	**Telephone:** 406-447-3268

PREA Coordinator Reports to: BACS CEO	**Number of Compliance Managers who report to the PREA Coordinator:** 2

Facility Information

Name of Facility: Helena Pre-Release			
Physical Address: 805 Collen St.		**City, State, Zip:** Helena MT 59601	
Mailing Address (if different from above): SAA		**City, State, Zip:** SAA	
The Facility Is:	☐ Military	☐ Private for Profit	X☐ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

Facility Website with PREA Information: **https://www.boydandrew.com/services/helena-pre-release-center/**

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

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

☐ ACA
☐ NCCHC
☐ CALEA
☐Other (please name or describe: X☐ N/A

If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe:
NA

Facility Director

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

Facility PREA Compliance Manager

Name: SAA			
Email: SAA		**Telephone:** SAA	

Facility Health Service Administrator X☐ N/A

Name: NA			
Email: NA		**Telephone:** NA	

Facility Characteristics		
Designated Facility Capacity:	104	
Current Population of Facility:	87	
Average daily population for the past 12 months:	94.28	
Has the facility been over capacity at any point in the past 12 months?	☐ Yes X☐ No	
Which population(s) does the facility hold?	☐ Females X☐ Males ☐ Both Females and Males	
Age range of population:	20-73	
Average length of stay or time under supervision	127.6 days	
Facility security levels/resident custody levels	Minimum	
Number of residents admitted to facility during the past 12 months		184
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:		184
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *30 days or more:*		164
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?		X☐ Yes ☐ No
Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):	☐ Federal Bureau of Prisons ☐ U.S. Marshals Service ☐ U.S. Immigration and Customs Enforcement ☐ Bureau of Indian Affairs ☐ U.S. Military branch X☐ State or Territorial correctional agency ☐ County correctional or detention agency ☐ Judicial district correctional or detention facility ☐ City or municipal correctional or detention facility (e.g. police lockup or city jail) ☐ Private corrections or detention provider ☐ Other - please name or describe: ☐ **N/A**	
Number of staff currently employed by the facility who may have contact with residents:		27
Number of staff hired by the facility during the past 12 months who may have contact with residents:		8
Number of contracts in the past 12 months for services with contractors who may have contact with residents:		0
Number of individual contractors who have contact with residents, currently authorized to enter the facility:		2
Number of volunteers who have contact with residents, currently authorized to enter the facility:		29

Physical Plant	
Number of buildings: **Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.**	2, including garage.
Number of resident housing units: **Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.**	0
Number of single resident cells, rooms, or other enclosures:	0
Number of multiple occupancy cells, rooms, or other enclosures:	47
Number of open bay/dorm housing units:	0
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	X☐ Yes ☐ No
Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	☐ Yes X☐ No

Medical and Mental Health Services and Forensic Medical Exams	
Are medical services provided on-site?	X☐ Yes ☐ No
Are mental health services provided on-site?	X☐ Yes ☐ No

Where are sexual assault forensic medical exams provided? Select all that apply.	☐ On-site X☐ Local hospital/clinic ☐ Rape Crisis Center ☐ Other (please name or describe:

Investigations

Criminal Investigations	
Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:	0- all criminal investigations are referred to the Helena Police Department.
When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.	☐ Facility investigators ☐ Agency investigators X☐ An external investigative entity
Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)	X☐ Local police department ☐ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☐ Other (please name or describe:☐ N/A

Administrative Investigations	
Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?	4
When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: Select all that apply	X☐ Facility investigators ☐ Agency investigators ☐ An external investigative entity
Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)	☐ Local police department ☐ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☐ Other (please name or describe: X☐ N/A

Audit Findings

Audit Narrative (including Audit Methodology)

The Prison Rape Elimination Act (PREA) on-site audit of the Helena Pre-Release Center (HPRC) was conducted September 8-9, 2020 by K. E. Arnold from Castle Rock, CO, a United States Department of Justice (USDOJ) 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 P.O. 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, Memorandums of Understanding (MOUs), organizational chart(s), the PREA video and HPRC PREA Handbook 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 Andrew Community Services (BACS) PREA Coordinator (PC). The majority of informational needs were addressed pursuant to telephonic contact and receipt of scanned documents.

Pursuant to contact with the Executive Director at Safe Space, the auditor has determined no HPRC sexual abuse allegations were received between the dates of September, 2018 and September, 2020. Safe Space Victim Advocates (VAs) receive training pursuant to the Office of Victims of Crime, a federal agency.

At approximately 8:00AM on September 8, 2020, 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.

The auditor notes the resident count at HPRC on the date of September 8, 2020 was 93.

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 17 residents (with varying lengths of stay) 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).

It is noted the 17 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 17 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 PC, were interviewed. The Random Sample of Staff Interview Guide was administered to this sample group of interviewees, comprising questions 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
Program Director (PD)
BACS PC
Designated Staff Charged with Monitoring Retaliation
Incident Review Team
Human Resources
Investigator (1)
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 (2)
Non-medical Staff Involved in Cross-Gender Strip or Visual Searches
Medical
Mental Health
Contractor/Volunteer

The auditor notes that he contacted the Helena Police Department (HPD) Administrative Office on three separate occasions (March 8, 2021, March 15, 2021, and March 23, 2021) for the purpose of facilitating an interview with a criminal investigator regarding sexual abuse investigation protocols, as applied to investigations at HPRC. The auditor was unable to talk to an individual during any of these calls as an automated telephone system is utilized. Subsequent to each contact, the auditor articulated a detailed message regarding the purpose of his call, as well as, the nature of the interview desired. The auditor did not receive a return telephone call with respect to any of the aforementioned attempts. In view of the time element, this interview cannot be facilitated.

In view of the relatively small number of staff assigned to the facility and staff days-off, one of the random staff interviewees was interviewed pursuant to the random staff and non-medical staff who perform cross-gender strip search questionnaires. By virtue of organizational structure and assignment of PREA responsibilities, the PD and the BACS PC were interviewed pursuant to three questionnaires apiece.

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:

GBTI (1)
Transgender/Intersex (2)
Disabled (one low vision, two physically disabled (one of these residents was also cognitively impaired)
Reported prior institutional sexual abuse (2)
Reported prior community sexual abuse (1)

The auditor reviewed 10 staff training records, 13 resident files, 12 staff HR files, five PREA investigative files, and other records reflected throughout the following narrative, prior to the audit, during the audit, and subsequent to completion of the same.

On September 8, 2020, 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 evidentiary 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 HPRC. When signing this document, contractors, vendors, service providers, volunteers, and visitors of HPRC are likewise certifying they have familiarized themselves with and understand PREA, agreeing to abide by this law.

From 8:30AM to 9:30AM on the same date, the HPRC PD, BACS PC, 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.

HPRC is comprised of two buildings, inclusive of the garage, 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 are located downstairs in B Wing (captured by camera(s). 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 areas, 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 36 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. The auditor notes camera resolution appears to be acceptable and coverage is exceptional.

Bathrooms and laundry are in the line of site for staff assigned to the bubble. There are no cameras in resident bathrooms or resident rooms.

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. Throughout the facility tour and duration of the on-site audit, the auditor validated staff procedures regarding bathroom and room entry.

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

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.

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 one's 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 our 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.

Summary of Audit Findings

Standards Exceeded

Number of Standards Exceeded: 3
List of Standards Exceeded: 115.231, 115.232, 115.263

Standards Met

Number of Standards Met: 38

Standards Not Met

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

PREVENTION PLANNING

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

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

115.211 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? 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

☐ **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 Chief Operations Officer (COO) 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 COO further self reports the facility has a written policy outlining how it will implement 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 1PS entitled PREA General Requirements, pages 1-8, addresses 115.211(a). The auditor finds this policy to be quite comprehensive and clearly commensurate with provision expectations.

Pursuant to the PAQ, the COO self reports the agency employs or designates an upper-level, agency-wide PREA Coordinator. The COO further self reports the BACS PC 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 position of the BACS PC is in the agency's organizational structure.

The auditor has reviewed the HPRC Organizational Chart and finds the Boyd Andrew Community Services (BACS PC) falls directly under the supervision of the BACS Chief Executive Officer (CEO) and the HPRC Program Director (PD) also serves as the HPRC PREA Manager (HPRC PM).

Pursuant to interview with the BACS PC, the auditor learned she does feel she has sufficient time to manage all of her PREA related responsibilities. Her primary designation as PC and Programs Compliance Officer (PCO) entails walking and talking with residents and staff at HPRC and Elkhorn Treatment Center (ETC). She facilitates all staff training at both facilities and resident training at HPRC. The PC is hands-on with all things PREA. Additionally, she tracks all staff and resident training.

In regard to making changes to the PREA program, she does make changes to PREA policies, if warranted. If any monetary expenditures are necessary, the PC addresses the same with the PD and BACS CEO.

In view of the above, the auditor finds HPRC substantially compliant with 115.211.

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.) □ 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 HPRC PD, HPRC does not contract with other agencies for the confinement of residents. Accordingly, the auditor has determined 115.212 is not applicable to HPRC however, since there is no deviation from standard requirements, the auditor finds HPRC substantially compliant with 115.212.

Standard 115.213: Supervision and monitoring

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

115.213 (a)

- Does the facility have a documented staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? X□ Yes □ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The physical layout of each facility? X□ Yes □ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The composition of the resident population? X□ Yes □ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The prevalence of substantiated and unsubstantiated incidents of sexual abuse? X□ Yes □ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors? 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 COO self reports 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 the last PREA audit, the average daily number of residents has been 97.6 and the average daily number of residents upon which the staffing plan is predicated is 97.6.

HPRC Policy 1PS entitled PREA General Requirements, page 6, section IV(A)(6) addresses 115.213(a).

The auditor's review of the 2018, 2019, and 2020 Staffing Plans signed by the PD, reveals the same are in compliance with the requirements of 115.213(a).

Pursuant to the Director, the facility does have a staffing plan. Adequate staffing levels to protect residents against sexual abuse and video monitoring are considered in the plan. Generally, three staff members are assigned to each shift. The staffing plan is documented and maintained electronically (on Sharepoint) in the Director's Office and Deputy Director's (DD) Office. The daily schedule is available to all staff.

Plan considerations include population and resident activity. Control Center (CC) staff have line of sight to all three wings, inclusive of camera reviews. One additional staff member is assigned to transports and he/she also conducts community checks of resident workers. The third staff member is also assigned in-house and conducts head counts, security checks, and searches. Of note, three security staff are always assigned as described above, during curfew hours (11:00PM-6:00AM, Monday through Friday and 12;00 Midnight-6:00AM, Saturday and Sunday.

Video monitoring is considered as part of the staffing plan. Thirty-six cameras are located inside and outside the facility. Thirty-four cameras have audio capability. Cameras located in specific locations have no audio capability.

The staffing plan is documented electronically and maintained on the PD's desktop, as well as, the DD, BACS PC, and BACS CEO.

When assessing adequate staffing levels and the need for video monitoring, the following issues are considered in staffing plan development;

a. The physical layout of each facility- The combination of staff and video monitoring must capture line of sight and blind spots. Cameras are positioned to capture resident activity in all areas accessible to them. Camera surveillance in the basement captures all movement in and out of staff offices, bathrooms, and group rooms.

b. The composition of the resident population- Age, ethnicity, Security Threat Groups (STG), and LGBTI population are considered in staffing plan development. It is reported these groupings are negligible in terms of concern. Generally, movement of residents within the facility, adjustment of staff supervision

responsibilities, or adjustment of the facility schedule/programming proves to be effective corrective strategies should concerns arise.

c. The prevalence of substantiated and unsubstantiated incidents of sexual abuse- Pursuant to monitoring of Sexual Abuse Review Team (SART) trends, we determine procedures/policies/staffing/camera issues in need of correction or change. As a result, staffing changes and/or staff security assignments or tour responsibilities may be changed. Additional training may also be implemented to offset any weaknesses.

d. Any other relevant factors- There are no other relevant factors.

In regard to monitoring staffing plan compliance, the PD reviews the daily roster and call-offs to assess vacancies. The shift supervisors also monitor the daily roster to ensure no vacancies. Monitoring ensures minimum staffing levels are met at all times.

In response to the aforementioned staffing plan considerations, the BACS PC asserts she assesses the frequency of sexual abuse/harassment reports and any correlation with staffing. Are there specific areas requiring additional staffing attention? Assessment of blind spots, if any, and a need to modify operations or resident access to specific areas is also considered.

Similarly, the PC assesses whether sexual abuse/harassment reports are originating from specific ethnic groups, LGBTI, sex offender population, and STGs. Do we need to realign staff supervision responsibilities, place specific staff in specific areas, or facilitate reassignment of resident rooms?

According to the PC, there are no other considerations.

Pursuant to the PAQ, the COO self reports that each time there is non-compliance with the staffing plan, the facility documents and justifies all deviations from the staffing plan. The COO further self reports 1. Employee Sick Leave; and 2. Staff requested time off; are the two most common reasons for deviation from the staffing plan during the last 12 months.

HPRC Policy 1PS entitled PREA General Requirements, page 6, section IV(A)(7) addresses 115.213(b).

The auditor's review of five random 2019 BACS/HPRC Deviation Forms reveals substantial compliance with 115.213(b). Based on the auditor's limited review, it appears there are no deviations from the staffing plan as positions are always filled by either staff from another discipline, overtime, etc.

The PD asserts all staffing plan non-compliance issues are documented. During the last 12 months, there has been no non-compliance issues as security posts are always filled. If a vacancy occurred, the same is documented on a Deviation Form, complete with a justification.

Pursuant to the PAQ, the COO 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 same.

HPRC Policy 1PS entitled PREA General Requirements, page 6, section IV(A)(8) addresses 115.213(c).

Pursuant to the auditor's review of the 2018, 2019, and 2020 Staffing Plans, it is apparent that the requirements of this provision are met. All of the above issues have been adequately addressed.

The PC asserts she attends HPRC staffing plan meetings and offers input accordingly.

In view of the above, the auditor finds HPRC substantially compliant with 115.213.

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 the facility does not have female 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 the facility does not have female 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? (N/A if the facility does not have female residents). □ Yes □ No X□ NA

115.215 (d)

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

- Does the facility have procedures that enables residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? 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

☐ **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 COO self reports the facility does not conduct cross-gender strip or cross-gender visual body cavity searches of residents. However, the following policy clearly reflects the same can be conducted pursuant to exigent circumstances or when conducted by a medical professional. The COO further self reports that zero cross-gender strip or cross-gender visual body cavity searches of residents were conducted during the last 12 months.

HPRC Policy 1PS entitled PREA General Requirements, pages 6 and 7, section IV(A)(9) addresses 115.215(a).

The non-medical staff (who may be involved in cross-gender strip or visual searches) interviewee asserts such searches are not facilitated at HPRC. Zero examples of exigent circumstances were provided.

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 last 12 months.

Given the totality of evidence, it is clear that cross-gender strip and/or visual body cavity searches are not conducted at HPRC. Clearly, policy allows for the same pursuant to exigent circumstances however, staff are trained to refrain from facilitation of the same.

In view of the above, the auditor finds HPRC substantially compliant with 115.215(a).

Pursuant to the PAQ, the COO self reports female residents are not housed at HPRC. During the facility tour, the auditor validated the same. Accordingly, 115.215(b) is not applicable to HPRC.

Pursuant to the PAQ, the COO self reports facility policy requires that all cross-gender strip searches and cross-gender visual body cavity searches are documented. As previously indicated, zero cross-gender strip searches and cross-gender body cavity searches are documented in the Exigent Circumstances Log.

HPRC Policy 1PS entitled PREA General Requirements, page 7, section IV(A)(10) addresses 115.215(c).

The BACS PC asserts zero cross-gender pat searches of female residents or strip or visual body cavity searches of male residents have been conducted at HPRC during the last 12 months.

Pursuant to the PAQ, the COO 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 COO further self reports policies and procedures require staff of the opposite gender to announce their presence when entering a resident housing unit.

HPRC Policy 1PS entitled PREA General Requirements, page 7, sections IV(A)(11) and (12) addresses 115.215(d).

The auditor notes during the facility tour, he reviewed camera angles and determined none of the video surveillance apparatus is capable of capturing the interior of either resident rooms or bathrooms.

All eight random resident interviewees self report female staff announce their presence, by gender, when entering their housing area or a resident bathroom. Additionally, all eight interviewees self report they are never naked or in full view of female staff (not including medical staff such as doctors, nurses) when toileting, showering, or changing clothing.

All 12 random staff interviewees self report female staff announce their presence, by gender, when entering housing and shower/toilet areas at HPRC. Similarly, all interviewees self report residents are able to dress, shower, and toilet without being viewed by staff of the opposite gender.

During the facility tour, the auditor notes female staff consistently announced their presence prior to entering resident housing wings.

Pursuant to the PAQ, the COO 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 COO further self reports such searches have not occurred at HPRC during the last 12 months.

HPRC Policy 1PS entitled PREA General Requirements, page 7, section IV(A)(10)(a)(3) addresses 115.215(e).

Eleven of 12 random staff interviewees self report the facility prohibits staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status and that they are aware of the relevant policy.

The transgender/intersex interviewees (one transgender and one intersex) assert they have not been placed in a housing area only for transgender/intersex residents and they have no reason to believe they were strip searched for the sole purpose of determining genital status.

Pursuant to the PAQ, the COO self reports 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 1PS entitled PREA General Requirements, page 7, section IV(A)(13) addresses 115.215(f).

The auditor's review of the Guidance on Cross-Gender and Transgender/Intersex Resident Pat Searches video and slide 51 of the BACS PREA training power point presentation reveals substantial compliance with 115.215(f). Additionally, the auditor's review of five 2019 and 2020 Staff Development and Training Record Forms substantiates completion of the requisite training during Orientation.

The BACS PC asserts the cross-gender pat search of female residents and search of transgender/intersex residents video is part of the PREA Orientation presentation and was presented during annual refresher training (ART) during 2018 and 2020. During the 2019 ART, the cross-gender and transgender/intersex search policies were reviewed.

The auditor's review of five random staff (all staff receive the same PREA training) PAQ training files reveals four staff received 115.215(f) training during 2018, 2019, and 2020. The remaining employee completed requisite training during 2018 and 2019.

All 12 random staff interviewees assert they completed training regarding cross-gender pat searches of female residents and respectful and professional searches of transgender/intersex residents. Training consisted of the above video presentation, discussion, and some demonstration. Training is provided during Orientation and PREA ART.

The auditor's on-site review of 10 random staff training files reveals staff received the requisite training during either Orientation or PREA ART.

In view of the above, the auditor finds HPRC substantially compliant with 115.215

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 COO self reports 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 3PS entitled Intake/Screening, pages 1 and 2, section II(A)(1)(b) and II(A)(2) addresses 115.216(a).

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 we would use our mental health counselor if the need arose for those with learning disabilities or residents that 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 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.

Given the above and inherent resource limitations, it is unlikely that residents requiring Braille and sign language services would be housed at HPRC. However, if such resources were required, before-hand knowledge would dictate accommodation.

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 BACS CEO responded in the affirmative. Specifically, she asserts that closed caption 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.

Three residents with disabilities [one with low vision and two physically disabled (one of which is also cognitively impaired), advise the facility provides information about sexual abuse and sexual harassment that they are able to understand.

Throughout the facility tour, the auditor observed PREA posters are properly positioned to ensure physically disabled or impaired residents have access to the information presented in the same. Likewise, printed materials appear to be age appropriate for the population.

Pursuant to the PAQ, the COO self reports the agency has established procedures to provide residents with limited English proficiency (LEP) 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 3PS entitled Intake/Screening, page 3, section II(A)(3) addresses 115.216(b).

HPRC contracts with CTS LanguageLink to provide interpretation services for residents who are LEP. A copy of the contract was included with PAQ materials and the auditor's review of the same reveals substantial compliance with 115.216(b).

The BACS PC asserts the HPRC PREA Handbook is not printed in Spanish however, if needed for an incoming resident, such translation or other accommodations would be made.

Pursuant to the PAQ, the COO self reports agency policy prohibits the 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-response duties under 115.264, or the investigation of the resident’s allegations. The COO 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 last 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-response duties, or the investigation of the resident's allegations.

HPRC Policy 3PS entitled Intake/Screening, page 3, section II(A)(4) addresses 115.216(c).

Nine of 12 random staff interviewees assert the agency does 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. Eight of 12 interviewees also assert the loss of the investigation and further injury to the victim are compelling reasons to employ 115.216(c) procedures. 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 last 12 months.

In view of the above, the auditor finds HPRC substantially compliant with 115.216.

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 who may have contact with residents? X□ Yes □ No

- Does the agency consider any incidents of sexual harassment in determining whether to enlist the services of any contractor, who may have contact with residents? 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)

- 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 COO 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 Policy 1.3.5.12 entitled Prison Rape Elimination Act, page 7, section 115.217 Hiring and Promotion Decisions addresses 115.217(a).

The auditor's review of the BACS application reveals the three 115.217(a) questions, as well as, a question related to sexual harassment [115.217(b)] are reflected within the application. The applicant signs the application and responds to the questions with a check mark in the correct box.

In addition to the above, a Boyd Andrew Reference Check Form is forwarded to previous institutional employers. 115.217(a), 115.217(b), 115.217(c), and 115.217(f) issues are addressed in this document.

The auditor's review of 10 random staff HR files reveals five of the affected staff were hired prior to the last PREA audit and accordingly, those files are not considered relative to the requirements of 115.217(a). With respect to the applicable five random staff files, the three 115.217(a) and one 115.217(b) questions were asked prior to the date of hire in three of five cases (questions were asked shortly following the hire date in the other two cases) and annually thereafter, dependent upon their date of hire.

In regard to promotions, one staff member was selected, as opposed to, promoted through merit procedures for a position of increasing responsibility and accordingly, she was not asked the requisite questions. In two other promotion cases, the three 115.217(a) and one 115.217(b) questions were asked with responses provided prior to the promotion.

The two contractors were hired prior to the last PREA audit and therefore, they are not included in the analysis for 115.217(a) and (b).

Of note, in the aforementioned applicable cases, applicants responded to the relevant questions as described in the analysis reflected above.

Pursuant to the PAQ, the COO 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).

As referenced in the narrative for 115.217(a), the relevant sexual harassment question is asked of prior institutional employers. In addition to the employment application and the criminal background record check, this document serves to further validate 115.217(b) compliance.

The auditor's review of five of six random Boyd Andrew Reference Check Forms reveals the same were discussed telephonically between HPRC/BACS staff and representatives from confinement facilities with notations reflected on the documents regarding responses. The auditor clearly finds this process is institutionalized, therefore validating compliance with 115.217(b) and (c).

In addition to the above, the auditor finds HPRC considers criminal background record checks, as well as, application certifications with respect to 115.217(b).

While HR staff are not assigned to HPRC, the PD responded to relevant HR questions. The PD asserts the facility considers prior incidents of sexual harassment when determining whether to hire or promote anyone, or to enlist the services of any contractors who may have contact with residents. Specifically, the relevant question is captured on the application and interview notes (verbal and then documented by the interviewer). Questions are asked on the relevant annual performance review document and a new application is completed for promotion applicants.

Pursuant to the PAQ, the COO 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 COO further self reports eight staff were hired during the last 12 months who may have contact with residents who have had criminal background record checks. This equates to 100% of staff hired during the last 12 months.

BACS Policy 1.3.5.12 entitled PREA Policy, page 7, section 115.117(c) addresses 115.217(c).

The auditor's review of six random 2019 and 2020 PAQ criminal background records checks reveals the same were conducted pursuant to 115.217(c). During the on-site audit, the auditor validated HPRC compliance with 115.217(c) pursuant to review of the five applicable staff HR files described in the narrative for 115.217(a). Criminal background record checks were conducted prior to the date of hire in four of the five cases. In the last case, the criminal background record check was completed 15 days subsequent to hire.

In regard to the Boyd Andrew Reference Check Form, the same was applicable in one randomly selected file and both prior institutional employers were contacted.

The HR interviewee asserts HPRC performs criminal background record 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. Department of Justice checks for contractors (Montana Criminal Record Background Checks) are conducted. The PD initiates all new staff, promotion, and contractor background checks. The BACS Business Manager initiates all 5-year re-investigations for staff and contractors.

Pursuant to the PAQ, the COO 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 COO further self reports zero criminal background record checks regarding contractors were completed during the last 12 months.

BACS Policy 1.3.5.12 entitled PREA Policy, page 8, section 115.217(d) addresses 115.217(d).

The auditor verified there are two contractors on board at HPRC and both were hired prior to December 1, 2015.

Pursuant to the PAQ, the COO 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).

The auditor's review of the random staff HR files articulated in the narrative for 115.217(a) reveals the latest 5-year re-investigations were conducted in all five staff cases, as well as, one contractor.

BACS Policy 1.3.5.12 entitled PREA Policy, page 8, section 115.217(f) addresses 115.217(f).

The auditor's findings regarding the application are clearly reflected in the narrative for 115.217(a).

The auditor's review of the facility annual performance review form reveals the three 115.217(a) questions are documented therein with boxes to check. Additionally, the “affirmative duty to disclose” admonition is also reflected in the same area on the form. The employee signs and dates the performance review.

The auditor's random review of four random 2019 (one) and 2020 (three) staff performance evaluations reveals substantial compliance with 115.217(f).

The HR interviewee asserts the agency asks all applicants and employees who may have contact with residents about previous misconduct as described at 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. He further asserts the facility imposes upon employees a continuing affirmative duty to disclose any such previous misconduct.

Pursuant to the PAQ, the COO 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).

The auditor notes the 115.217(g) caveat is clearly scripted at the end of the application. Again, the applicant signs and dates the same.

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.

The HR interviewee asserts when a former employee applies for work at another institution, upon request from that institution, facility staff provide information regarding substantiated allegations of sexual abuse/ harassment involving the former employee, unless prohibited by law.

In view of the above, the auditor finds HPRC substantially compliant with 115.217.

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 COO self reports the facility has not acquired a new facility or made a substantial expansion or modification to existing facilities since the last PREA audit.

Pursuant to the PAQ, the COO self reports the facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since the last PREA audit.

As the auditor finds no deviation from standard, HPRC is deemed substantially compliant with 115.218.

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? (N/A if agency *always* makes a victim advocate from a rape crisis center available to victims.) X□ Yes □ No □ NA

- 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 agency follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.) 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? (N/A if agency *always* makes a victim advocate from a rape crisis center available to victims.) 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 COO 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 COO further self reports when conducting a sexual abuse investigation, the agency investigators follow a uniform evidence protocol.

HPRC Policy 4PS entitled Reporting, page 8, section II(E)(1) and (2) addresses 115.221(a).

The auditor's review of two administrative investigations reveals substantial compliance with 115.221(a). One investigation and findings was referred to HPD while the other investigation was determined to be non-PREA related. Investigations were timely, addressed the evidence discovered, and its relevance to the "big picture".

All 12 random staff interviewees assert they know and understand the agency's protocol for obtaining usable physical evidence if a resident alleges sexual abuse. Ten of the 12 interviewees responded appropriately to all four requirements of the uniform evidence protocol, ensuring maximization of the potential for obtaining usable physical evidence.

In addition to the above, interviewees identified at least one HPRC administrative sexual abuse/ harassment investigator and the criminal investigative agency (HPD).

During the facility tour, the auditor noted juvenile/youth residents are not housed at HPRC. The protocol was adapted from or is otherwise based on the most recent edition of the DOJ'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.

The auditor has reviewed the evidence protocol articulated in the Helena Pre-Release Center's Coordinated Response to PREA Incidents flow chart 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 and 115.265.

Of note, the National Institute of Corrections (NIC) course referenced in the narrative for 115.234 substantiates compliance with 115.221(b).

Pursuant to the PAQ, the COO self reports the facility offers to all residents who experience sexual abuse access to forensic medical examinations at a community hospital. The COO 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 COO self reports the facility would document efforts to provide SANEs or SAFEs. The COO self reports that zero forensic medical examinations were conducted during the last 12 months.

HPRC Policy 4PS entitled Reporting, page 8, section II(E)(3) addresses 115.221(c).

The SANE interviewee is an Emergency Room (ER) Manager at St. Pete's Hospital. She asserts 11 ER Nurses are SANE-trained pursuant to a state funded national standards training program provided once per year. Nineteen additional ER Nurses are trained to facilitate a "rape kit".

SANE-trained Nurses work in conjunction with an 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 any of the 19 aforementioned nurses be able to facilitate the kit.

SANE-trained Nurses are available on a 24/7 basis. If necessary, a SANE-trained Nurse can be re-called to facilitate the forensic examination.

Infection prophylaxis is part of the forensic examination. Additionally, any applicable testing, dependent upon the nature of the circumstances, is provided as part of the forensic examination process.

Pursuant to the PAQ, the COO 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 COO 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 4PS entitled Reporting, pages 8 and 9, section II(E)(4) addresses 115.221(d).

The auditor has reviewed an MOU between the HPRC COO and leadership at Safe Space (dated June 19, 2020). Duties and expectations for both HPRC staff and Safe Space are clearly articulated in the MOU. Confidentiality is also addressed in the MOU.

The BACS PC asserts one mental health staff member has completed the National Institute of Corrections (NIC) course entitled Victim Services and PREA: A Trauma Informed Approach. She would generally provide mental health services if victim advocates from Safe Space were not available. The auditor's review of her test reveals substantial compliance with 115.221(d).

According to the BACS PC, HPRC makes available to residents victim advocates (VAs) pursuant to Safe Space. 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 HPRC and Safe Space.

The BACS PC asserts zero residents who reported a sexual abuse at HPRC were at the facility during the on-site audit.

Pursuant to the PAQ, the COO 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 4PS entitled Reporting, page 9, section II(E)(5) addresses 115.221(e).

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.

In view of the above, the auditor finds HPRC substantially compliant with 115.221(e).

Pursuant to the PAQ, the COO 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 the standards.

HPRC Policy 4PS entitled Reporting, page 9, section II(E)(6) and (7) addresses 115.221(f).

The lead criminal investigation agency/HPD shall follow HPD sexual assault investigative protocols and PREA standards regarding investigations. HPRC holds an MOU with HPD for criminal investigation of all sexual abuse and sexual assault matters.

The auditor reviewed MOUs dated February 23, 2017, July 9, 2019, and July 13, 2020 between the HPRC PD/Chief Executive Officer (CEO) of BACS and the 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.

In view of the above, the auditor finds HPRC substantially compliant with 115.221.

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 the policy describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for conducting criminal investigations. See 115.221(a).) X□ Yes □ No □ NA

115.222 (d)

- Auditor is not required to audit this provision.

115.222 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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 COO self reports 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 COO further self reports eight allegations of sexual abuse or sexual harassment were received during the last 12 months. Five allegations resulted in administrative investigations and three resulted in criminal investigations. The aforementioned administrative and criminal investigations were completed during the last 12 months.

HPRC Policy 4PS entitled Reporting, page 2, section II(A)(11) addresses 115.222(a).

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 that 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 for investigation.

Pursuant to the PAQ, the COO self reports 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 COO 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 COO, the agency documents all referrals of allegations of sexual abuse or sexual harassment for criminal investigation.

HPRC Policy 4PS entitled Reporting, pages 2 and 3, section II(A)(12) addresses 115.222(b).

The investigative staff interviewee asserts agency policy requires that allegations of sexual abuse/ 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. If a crime has been committed, the matter is referred for criminal investigation.

The auditor reviewed the aforementioned website and found the MOU to be maintained thereon.

The auditor's review of the MOU between HPRC and HPD reveals the same is commensurate with 115.222(c). Specifically, both the agency and HPD responsibilities are articulated in the document.

The MOU is posted on the BACS website.

In view of the above, the auditor finds HPRC substantially compliant with 115.222.

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 confinement? X□ Yes □ No
- Does the agency train all employees who may have contact with residents on: The common reactions of sexual abuse and sexual harassment victims? 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 COO 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 6PS entitled Training, page 1, section II(A)(1-10) addresses 115.231(a).

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 transgender pat searches developed by the National PREA Resource Center (PRC) in video, power point, instructors manual, and webinar formats;
Boyd Andrew PREA training (power point) provided during employee orientation; and
BACS PREA Power Point provided during PREA ART.

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.

All 12 random staff interviewees assert they have received training regarding the aforementioned topics. They have received this training during PREA Orientation, dependent upon their entry on duty date with BACS, and during PREA ART.

The auditor's on-site review of three of four random employee files (staff hired between 2018 and 2020) reveals timely completion of PREA Orientation training while timely PREA ART training has been completed in nine of 10 random staff files. Of note, seven staff were hired prior to July, 2018 and all but one staff member completed three PREA ART sessions during 2018, 2019, and 2020.

In summary, affected staff completed HPRC Staff Development and Training Record Forms reflecting their signature and date for receipt and understanding of the information received. The above documents pertain to staff across all disciplines.

In addition to the above, the auditor reviewed 20 2018 and 2019 National Institute of Corrections (NIC) certificates issued to staff for various NIC courses. Staff represented all facility disciplines.

Clearly, pursuant to the auditor's review, staff are required to complete one or more PREA on-line courses presented by NIC on an annual basis. The auditor finds 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 expectations regarding this standard.

Pursuant to the PAQ, the COO self reports the training is tailored to the gender of the residents at the facility. The COO further self reports employees who are reassigned from facilities housing the opposite gender receive the same training as that provided to HPRC staff. Specifically, HPRC and ETC PREA training is interchangeable.

HPRC Policy 6PS entitled Training, page 2, section II(G) addresses 115.231(b).

According to the BACS PC, staff transferring from ETC (female facility) receive the same training as that provided at HPRC and vice-versa. Accordingly, staff transferring from ETC to HPRC and vice-versa are not re-trained.

Pursuant to the PAQ, the COO self reports 27 staff employed by the facility, who have contact with residents, were trained or retrained in PREA requirements. This equates to 100% of all staff assigned to the facility. According to the COO, between trainings, staff receive additional PREA training pursuant to policy reviews. Additionally, staff are assigned PREA ART through the NIC website. The COO self reports employees who may have contact with residents receive PREA ART. The auditor finds this practice above and beyond standard requirements as the standard requires refresher training every two years.

Pursuant to the PAQ, the COO self reports the agency documents that employees who have contact with residents understand the training they have received through employee signature or electronic verification.

HPRC Policy 6PS entitled Training, page 2, section II(C) addresses 115.231(d).

In view of the above, the auditor finds HPRC exceeds standard expectations with respect to 115.231.

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

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 COO 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 COO further self reports 29 volunteers and two 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 6PS entitled Training, page 2, section II(D) addresses 115.232(a).

The two contractor and two volunteer interviewees assert they have been trained in their responsibilities regarding sexual abuse/sexual harassment prevention, detection, and response, per agency policy and procedure. As the two contractors work both as contractors with a work program and one works part-time with security, they receive PREA ART. The contractor who also works with security receives the same PREA ART provided to all staff. Minimally, the last contractor PREA ART was provided in 2019 for all.

COVID-19 has impacted volunteer access and accordingly, 2020 PREA ART training has been adversely impacted for them.

The auditor's review of 2018, 2019, and 2020 HPRC PREA ART Staff Development and Training Record Forms reveals substantial compliance with 115.232. Additionally, the auditor's review of three HPRC PREA Compliance Acknowledgments (addressing 2018 and 2019), as well as, two Volunteer, Vendor, Contractor Training Record Forms (addresses 2018 and 2019) reveals substantial compliance with 115.232(a).

Pursuant to the PAQ, the COO 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 COO 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 6PS entitled Training, page 2, section II(E) addresses 115.232(b).

The BACS PC asserts due to the level of contact the contractors have with residents, one receives the same training as HPRC staff and the other one receives computer generated training and Power Point training. Volunteers receive the Boyd Andrew Volunteer/Vendor/Contractor PREA Training and the same reveals substantial compliance with 115.272(b).

The auditor's review of the PAQ power point presentation entitled Boyd Andrew Volunteer/Vendor/Contractor PREA Training reveals substantial compliance with 115.232(b). This resource minimally addresses the zero-tolerance policy regarding sexual abuse and sexual harassment and information regarding reporting.

The contractor and volunteer interviewees assert training includes how to report sexual abuse/harassment, how sexual abuse/harassment impacts the resident population, "red flags regarding sexual abuse/ harassment, and zero tolerance regarding sexual abuse/harassment. As previously mentioned, contractors are provided essentially the same training as HPRC staff.

The auditor's review of 2018 and 2019 contractor Staff Development and Training Record Forms, as well as, a 2019 form for another contractor reveals substantial compliance with 115.232. Additionally, the auditor's review of 2019 and 2020 Volunteer, Vendor, Contractor Training Record Forms relative to three volunteers reveals substantial compliance with 115.232. All volunteers affix their signature and date to these forms, signifying understanding of the subject-matter presented.

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

HPRC Policy 6PS entitled Training, page 2, section II(F) addresses 115.232(c).

In view of the fact standard provisions do not require training at prescribed intervals following provision of the initial 115.232 PREA training, the auditor finds HPRC exceeds standard requirements as training is provided on an annual basis.

In view of the above, the auditor finds HPRC exceeds 115.232 expectations.

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 COO self reports 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 COO further self reports 184 residents, who were admitted to HPRC during the last 12 months, were given the above information at intake. This equates to 100% of admissions during the referenced time frame.

HPRC Policy 3PS 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 PREA, 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.

The intake staff interviewee asserts 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 and PREA policies. Additionally, residents are educated regarding their rights to be free from sexual abuse/sexual harassment, right to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents pursuant to review of the PREA video.

All eight 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) at intake and subsequently, they viewed the PREA video during case manager PREA Orientation. Additionally, all eight 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, random resident interviewees received this information at intake (for those residents who arrived after March, 2020, many were placed in 14-day COVID-19 quarantine and accordingly, they received orientation immediately following the same). One interviewee asserts he did not receive orientation training until 14 days following intake.

The auditor's on-site review of 13 random resident files reveals all received initial PREA information on the date of admission (at intake). They subsequently received case manager orientation within one week of either intake or completion of the aforementioned quarantine.

The auditor's review of the HPRC PREA Handbook reveals substantial compliance with 115.233(a). The exception is noted in the narrative for 115.253(b).

In addition to the above, the auditor's review of five random 2019 Receipts of HPRC Treatment Program PREA Handbook reveals the same were received in a timely manner (during intake). Receipt of the Department of Corrections (DOC) Offender PREA Acknowledgment Form and the two referenced policies further substantiates compliance with 115.233(a).

Pursuant to the PAQ, the COO 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 BACS PC asserts all new HPRC commitments are provided the same PREA Handbook and PREA Orientation. The auditor verified the same pursuant to document reviews as previously indicated.

The BACS PC further relates the following breakdown regarding resident transfers to HPRC:

13 from the community;
23 from prison;
66 from Assessment/Sanction facilities; and
82 from treatment facilities.

All of the above residents received the same HPRC PREA Handbook and Orientation.

According to the staff member who performs intakes, residents are made aware of the rights articulated in 115.233(a) immediately upon arrival (during Intake) and following release from quarantine.

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

Pursuant to the PAQ, the COO 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 3PS entitled Intake/Screening, page 2, 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 PD self reports that he has an education background with special education and HPRC would use the facility mental health counselor 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 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.

The auditor's review of the HPRC PREA Handbook reveals the same is 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. Further discussion regarding education of residents with disabilities is scripted in the narrative for 115.216.

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

HPRC Policy 3PS entitled Intake/Screening, page 2, section II(A)(1)(d) and (f) addresses 115.233(d). This policy stipulates resident HPRC training that staff 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. Of course, as previously indicated, COVID-19 procedures have forced modification of this practice.

The auditor's review of four completed 2019 and 2020 State of Montana DOC Offender PREA Acknowledgments and accompanying PREA Orientation Certificates substantiates compliance with 115.233(d), in addition to, those documents referenced in the narrative for 115.233(a).

The auditor's review of two posters reveals substantial compliance with 115.233(e). One poster addresses zero tolerance and reporting options while the other poster addresses victim support. The HPRC Handbook is addressed throughout the narrative for 115.233.

In view of the above, the auditor finds HPRC substantially compliant with 115.233.

Standard 115.234: Specialized training: Investigations

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

115.234 (a)

- In addition to the general training provided to all employees pursuant to §115.231, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators receive training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).)

  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 COO self reports agency policy requires that investigators are trained in conducting sexual abuse investigations in confinement settings.

HPRC Policy 6PS entitled Training, pages 2 and 3, section II(H)(1) addresses 115.234(a).

According to the investigative staff interviewee, she completed the NIC course (Basic Conducting Sexual Abuse Investigations in a Confinement Setting). The basic course was a three hour on-line course which included case scenarios.

The auditor's review of five NIC certificates reveals four staff completed the PREA: Investigating Sexual Abuse in a Confinement Setting: Advanced Investigations Course. The PD completed the same course in both 2019 and 2020.

HPRC Policy 6PS entitled Training, page 3, section II(H)(2) addresses 115.234(b).

Pursuant to the auditor's research of the NIC website, the training criteria referenced in the above policy is addressed. Additionally, the auditor's review of the training plan reveals substantial compliance with 115.234(b).

According to the investigative interviewee, the specialized training referenced above addresses 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 COO self reports the agency maintains documentation showing that investigators have completed the required training. The COO further self reports that four administrative PREA investigators are currently utilized at HPRC and all four have completed requisite training.

HPRC Policy 6PS entitled Training, page 3, section II(H)(3) addresses 115.234(c).

In view of the above, the auditor finds HPRC substantially compliant with 115.234.

Standard 115.235: Specialized training: Medical and mental health care

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

115.235 (a)

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
  X□ Yes □ No □ NA

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) X□ Yes □ No □ NA

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to victims of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) X□ Yes □ No □ NA

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) X□ Yes □ No □ NA

115.235 (b)

- If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency does not employ medical staff or the medical staff employed by the agency do not conduct forensic exams.)

  X□ Yes □ No □ NA

115.235 (c)

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) X□ Yes □ No □ NA

115.235 (d)

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

- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.) 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 COO self reports the agency has a policy related to the training of medical and mental health practitioners who work regularly in its facilities. The COO further self reports the 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 requisite specialized training.

HPRC Policy 3.5 entitled Medical and Mental Health, page 3, section III(A) addresses 115.235(a).

According to the medical and mental health interviewees, they received the requisite specialty training. They completed the three hour on-line NIC courses PREA: Medical Health Care for Sexual Assault Victims in a Confinement Setting; and PREA 201 for Medical and Mental Health Practitioners and PREA: Behavioral Health Care for Sexual Assault Victims in a Confinement Setting (mental health interviewee). The courses included how to detect and assess signs of sexual abuse/harassment, how to preserve physical evidence of sexual abuse, how to respond effectively and professionally to victims of sexual abuse/harassment, and how and to whom to report allegations or suspicions of sexual abuse and sexual harassment.

The auditor's review of NIC certificates for the following requisite courses reveals substantial compliance with 115.235:

PREA: Medical Health Care for Sexual Assault Victims in a Confinement Setting;
PREA 201 for Medical and Mental Health Practitioners; and
PREA: Behavioral Health Care for Sexual Assault Victims in a Confinement Setting.

Pursuant to the PAQ, the COO self reports 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 115.235(b) is not applicable to HPRC.

Pursuant to the PAQ, the COO 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.

A discussion regarding the requisite information is addressed in the narrative for 115.235(a).

The auditor reviewed 2019 and 2020 training documentation for the previous and current medical/mental health providers at HPRC and has determined they did complete PREA Orientation and PREA ART courses provided to all HPRC staff. Specifically, the auditor reviewed HPRC Staff Development and Training Record Forms and various PREA-related NIC courses for both employees and finds validation of 115.235(d).

In view of the above, the auditor finds HPRC substantially compliant with 115.235.

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 disability? 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 COO 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 3PS entitled Intake/Screening, page 3, section II(B) addresses 115.241(a).

According to the staff who performs screening for risk of victimization and abusiveness interviewee, he 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 she does not facilitate such screenings. She does not actually conduct Initial PREA Screenings as she is responsible for the conduct of 30-day reassessments.

Of the eight random resident interviewees, five 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. One interviewee asserts he was questioned regarding three of the four previously mentioned topics and one interviewee asserts he didn't recall being asked requisite questions. Two interviewees assert they were questioned regarding the above following completion of the previously referenced quarantine.

Of the three random resident interviewees who arrived at HPRC and asserted they either did not recall being initially screened/were not initially screened, or they were not initially screened on the day of arrival, the auditor reviewed their files and found two were screened upon arrival at HPRC. The auditor did not review the third interviewee's file.

The auditor's on-site review of 13 random resident files reveals the initial victimization/aggressor screening was conducted on the day of arrival and in a thorough manner.

Pursuant to the PAQ, the COO self reports facility 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 COO further self reports that 184 residents (100% who 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 during the last 12 months.

HPRC Policy 3PS entitled Intake/Screening, page 3, section II(A) addresses 115.241(b).

The auditor's review of four 2019 and 2020 PAQ HPRC PREA Risk Assessments reveals the same were conducted on the date of arrival at HPRC.

Pursuant to the staff who performs initial PREA screening interviewee, incoming residents are screened for risk of sexual victimization or risk of sexually abusing other residents at Intake, within one to two hours of arrival.

Pursuant to the PAQ, the COO 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 COO 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 3PS entitled Intake/Screening, page 4, section II(A)(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; and
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 tool.

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 (KV) or Potential Victim (PV) or Known Aggressor (KA) or Potential Aggressor (PA). 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 and are identified as Unrestricted.

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 four PAQ 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 the PREA classification.

The staff who perform screening for risk of victimization and abusiveness interviewee asserts the initial screening tool considers whether resident is a PV/PA/KV/KA, identifies as LGBTI, history of sexual abuse or victimization, feelings regarding sexual safety at HPRC, height/weight, and age. Additionally, the screener's assessment and their feelings are integral to the process.

The interviewee asserts a closed door PREA screening interview is facilitated in the Urinalysis Room. The interview is conducted one-on-one (screener and resident) and the screener reads the questions to the resident, documenting responses on the screening tool. Prior to the actual screening, the screener reviews pre-screening materials, using the same to validate the resident's responses.

HPRC Policy 3PS entitled Intake/Screening, page 3, section II(A)(2) addresses 115.241(e).

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 COO self reports policy requires that the facility reassesses 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 COO further self reports 164 residents (100% during the last 12 months) 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 3PS entitled Intake/Screening, page 3, section II(A)(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 staff responsible for risk screening (reassessments) interviewee asserts reassessments are conducted between days 20 and 30 of arrival at HPRC.

Of the eight random resident interviewees, five residents assert they did not receive a reassessment. One of these interviewees asserts he does not recall whether he received a reassessment.

Two interviewees assert they were reassessed within 30-days of arrival at HPRC.

The auditor's review of five of six files related to those interviewees who asserted they did not receive reassessments or they don't recall, as reflected above, reveals that, in five cases, reassessments were completed in a comprehensive and timely manner. Two additional subject random resident interviewees were not yet due for reassessment in view of their arrival date.

The auditor's on-site review of 13 random resident files, inclusive of the files referenced in the preceding paragraph, reveals timely and comprehensive reassessments were completed in eight cases. Of course, as previously referenced, two additional reassessments were not yet due. Accordingly, three reassessments were determined to be untimely.

In view of the above, the auditor finds HPRC substantially compliant with 115.241(f).

Pursuant to the PAQ, the COO 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 resident's 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.

Two reassessments were included in the PAQ and the BACS PC asserts the affected residents returned to HPRC following confinement [serving sanction(s)] in another facility. The PC further asserts zero residents were reassessed at HPRC due to a referral, request, or incident of sexual abuse.

According to the staff member who facilitates PREA screening reassessments, she facilitates all reassessments. Reassessments 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.

The interviewee asserts the PD would alert her regarding recent facility sexual abuse and she would facilitate the reassessment. The same situation is applicable to receipt of additional information.

Pursuant to the PAQ, the COO self reports 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 3PS entitled Intake/Screening, page 4, section II(A)(6) addresses 115.241(h).

The auditor's review of the BACS Disclaimer is commensurate with the above policy. The language is clear and the resident signs and dates the same.

According to the staff responsible for risk screening (initial and reassessment) 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 specific questions.

HPRC Policy 3PS entitled Intake/Screening, page 4, section II(A)(7) addresses 115.241(i). The auditor also notes the HPRC PREA Handbook specifically reflects dissemination of information is limited to those staff with a "need to know" (e.g. decision-making).

According to the BACS PC, the PD, BACS PC, Deputy Director, and security supervisors constitute the individuals who have access to a resident's risk assessment within the facility in order to protect sensitive information from exploitation. Initial assessments and reassessments are stored in the BACS PC's Office and the aforementioned staff have access to the same.

The two staff responsible for risk screening corroborated the statement of the BACS PREA Coordinator, stating the PD, Deputy Director, and BACS PC 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).

In view of the above, the auditor finds HPRC substantially compliant with 115.241.

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

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: transgender residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) X□ Yes □ No □ NA

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) 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 COO self reports the agency/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 3PS entitled Intake/Screening, page 4, section II(B)(2) addresses 115.242(a).

The auditor's review of a document entitled Active Room Assignments reveals residents are assigned as reflected in the following sentences. KVs/PVs and KAs)/PAs are noted by room assignment, victims and aggressors are not housed in the same room. Residents classified as Unrestricted are housed with either classification. The auditor's review of the above document reveals no disparity in terms of the aforementioned housing practice.

According to the BACS PC, risk screening information is translated into PAs, KAs, KVs, and PVs and they are geographically separated by room or wing. Staff are aware of the classifications and extra precautions may be employed.

Residents scoring as Unrestricted can be housed with either classification. The BACS PC monitors the grid at least monthly to ensure compliance with 115.242(a).

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. Their statements corroborate that of the BACS PC.

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

HPRC Policy 3PS entitled Intake/Screening, page 4, section II(B)(3) addresses 115.242(b).

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

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

HPRC Policy 3PS entitled Intake/Screening, page 5, section II(B)(4) addresses 115.242(c).

The BACS PC asserts staff and resident perceptions of personal safety are a primary consideration when determining housing and programming assignments. Housing, programming, and work strategies are addressed in the narratives for 115.242(a) and (b). 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 are a consideration in terms of placement.

The transgender and intersex resident interviewees assert staff have questioned them as to their personal safety at HPRC. Neither interviewee believes they have been placed in a housing area designated for only transgender/intersex residents, nor have they been strip searched for the sole purpose of determining genitalia.

HPRC Policy 3PS entitled Intake/Screening, page 5, section II(B)(6) addresses 115.242(d).

The BACS PC 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. In-house programming is supervised by staff.

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 3PS entitled Intake/Screening, page 5, section II(B)(9) addresses 115.242(e).

The BACS PC asserts each showering resident has access to an individual shower. If a transgender/ intersex resident requests separate showering from the resident population, the request is directed to the PD. Separate showering is addressed during resident orientation. If requested, the shower would be closed at a specific time to allow for the same. Staff in the bubble have direct line of sight for purposes of ensuring other residents do not enter the bathroom.

The two staff responsible for risk screening interviewees corroborate the statement of the BACS PC.

The transgender/intersex resident interviewees assert they are able to shower in the absence of other residents. They personally choose to shower at times when other residents are not using the showers and they manage their own showers.

HPRC Policy 3PS entitled Intake/Screening, pages 5 and 6, section II(B)(10) addresses 115.242(f).

According to the BACS PREA PC, HPRC 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 HPRC 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 only for LGBTI residents.

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

The auditor's review of relevant housing grid(s) and interview results reveals LGBTI residents are not housed in selected rooms, wings, housing areas, etc.

In view of the above, the auditor finds HPRC substantially compliant with 115.242.

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 COO 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 4PS entitled Reporting, page 1, section II(A)(1) and (2) addresses 115.251(a). Requisite information is provided during resident intake and orientation.

The auditor's review of the HPRC PREA Handbook reveals 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 telephone numbers for the Helena Police Department and Missoula YWCA Pathways Program are provided.

The HPRC PREA Handbook reflects these telephone numbers are posted near the resident telephones in each housing unit.

All 12 random staff interviewees were able to identify at least two resident reporting options with respect to the above. Options ranged from reporting to staff, contacting HPD, submission of an emergency grievance, contact duty station staff, submit a written report, third-party report, and contact the PREA Hotline (Missoula YWCA Pathways).

All eight random resident interviewees were able to articulate at least two reporting options. Reporting options cited were reporting to staff, submit a kite or written report to staff, telephone HPD or MDOC, third party report, submit an emergency grievance, contact the PREA Hotline, and advise family.

During the facility tour, the auditor noted numerous informational posters bearing information regarding reporting, hung near the resident telephones. The combination of the HPRC PREA Handbook, posters, and resident training clearly provide residents ample opportunities to be informed regarding reporting options.

Pursuant to the PAQ, the COO 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 4PS entitled Reporting, pages 1 and 2, section II(A)(3-5) addresses 115.215(b).

According to the BACS PREA PC, residents may report incidents as referenced in the narrative for 115.251(a) to HPD or Missoula YWCA Pathways. The auditor notes the HPRC relationship with Missoula YWCA Pathways is relatively new.

The auditor's review of a Memorandum of Understanding (MOU) with Missoula YWCA Pathways reveals that while certainly supportive of 115.251(b) requirements, the same does not meet muster regarding the immediate provision of information to designated officials regarding the incident. The Missoula YWCA Pathways MOU does contain such verbiage with the caveat of a need for the resident's written release of information authorization regarding the specifics of the report.

Pursuant to follow-up questioning, the BACS PC asserts Missoula YWCA Pathways officials agree to immediately provide the substance of the report to either the HPRC PD or Elkhorn Treatment Center (ETC) Deputy Director (DD) while respecting a victim's request for anonymity. However, if the victim or reporter has concerns with conveying specifics to HPRC staff regarding the alleged incident, the same could inhibit the timeliness and effectiveness of any investigation.

All in-state calls are free-of-charge and the same are not monitored or recorded.

The provision is clear, in that, the entity must be able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials. Based on the above analysis, the aforementioned caveat could indirectly impede the timeliness and effectiveness of an investigation.

The auditor notes that HPD could fulfill the requirements of 115.251(b) however, the same will require negotiation to ensure compliance with 115.251(b). Specifically, any sexual abuse/harassment allegation must be reported to a designated HPRC point of contact.

The BACS PC asserts Missoula YWCA Pathways is the designated private entity for receipt of sexual abuse/harassment reports. Procedures are clearly articulated in an MOU between BACS and Missoula YWCA Pathways. As reflected in the above narrative regarding the same, Missoula YWCA Pathways will not provide any information that may reveal the victim's identity, with the exception of that noted above. Accordingly, the BACS PC will be working with either/or HPD or Missoula YWCA Pathways to meet compliance with 115.251(b).

In view of the above, the auditor is imposing a 180-day corrective action period in which the BACS PC will address this issue with the aforementioned entities, crafting the agreement in amended MOU(s), and training HPRC stakeholders to achieve institutionalization. Throughout the remainder of the corrective action period, the BACS PC will forward to the auditor any investigations wherein this reporting procedure was utilized by the reporting resident. Additionally, the auditor will facilitate a test of the system to ensure the same has been institutionalized.

The corrective action will commence upon issuance of this report and conclude no later than April 30, 2021.

To demonstrate compliance, the BACS PC will forward to the auditor a copy of the amended MOU and a copy of training certifications for all stakeholders, validating requisite training was completed. Any modifications to the HPRC PREA Handbook or any other documents will also be forwarded to the auditor. The auditor will include all of this information in the audit file and he will subsequently determine the status of compliance.

February 26, 2021 Update:

The auditor has been provided a copy of an MOU between the Boyd Andrews COO and the CEO of Community Counseling and Correctional Services (CCCS) (a private non-profit provider of community confinement services located in Butte, MT) wherein the requisite parameters of 115.251(b) are demonstrated. The CCCS telephone number is highlighted on amended posters hung near the resident telephones and the HPRC PREA Handbook has been amended to reflect relevant information. A document reflecting the names of 20 residents reveals they have been provided the amended HPRC PREA Handbook. Additionally, a copy of an email forwarded to all HPRC staff users reveals the aforementioned information. Finally, the auditor's February 26, 2021 test of the system reveals compliance with 115.251(b).

In view of the above, the auditor now finds HPRC staff have completed and implemented requisite corrective action and HPRC is now substantially compliant with 115.251(b).

All eight random resident interviewees assert incidents can be reported to family/friends who can submit a report without having to give the resident's name.

Pursuant to the PAQ, the COO 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 COO further self reports staff are required to document verbal reports as soon as possible following receipt of the same. Upon follow-up with the BACS PC, the PAQ is modified to read such reports are documented immediately.

HPRC Policy 4PS entitled Reporting, page 2, section II(A)(7) addresses 115.251(c).

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.

Six of eight random resident interviewees assert residents can make reports of sexual abuse or sexual harassment either in person or in writing and a report can be made by a third party so that the resident does not have to be named.

Pursuant to the PAQ, the COO self reports the agency has established procedures for staff to privately report sexual abuse and sexual harassment of residents. The COO further self reports staff can verbally, written, and electronically or via email, submit a report. Third party reporting forms are a means as well. As reflected at 115.231, staff receive training regarding reporting options. The same is provided in the form of a Power Point presentation.

HPRC Policy 4PS entitled Reporting, page 1, section II(A)(1) addresses 115.251(d).

All 12 random staff interviewees were able to identify at least two methods of privately reporting sexual abuse and sexual harassment of residents. Reporting methods include, but are not limited to: contact HPD; contact BACS PD; email to PD/BACS PC/security supervisors; contact PD/BACS PC via cell phone; report to supervisor behind closed doors; and submit a written report.

In view of the above, the auditor finds HPRC substantially compliant with 115.251.

Standard 115.252: Exhaustion of administrative remedies

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

115.252 (a)

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

115.252 (b)

- Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.) 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 COO self reports the agency has an administrative procedure for dealing with resident grievances regarding sexual abuse.

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

Pursuant to the PAQ, the COO 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 COO 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 4PS entitled Reporting, page 3, section II(A)(13)(a-d) addresses 115.252(b).

The auditor has reviewed the HPRC PREA Handbook and finds the requisite information identified in this provision is accurately captured at pages 6 and 7, section entitled Grievance Procedure (a).

Pursuant to the PAQ, the COO 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 COO 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).

The auditor's review of the HPRC PREA Handbook reveals the requisite information identified in this provision is accurately captured at page 7, section entitled Grievance Procedure (b).

Pursuant to the PAQ, the COO 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 COO further self reports that zero grievances have been filed (alleging sexual abuse)

during the last 12 months. Finally, the COO 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 4PS entitled Reporting, page 4, section II(A)(13)(f)(1-4) addresses 115.252(d).

The auditor's review of the HPRC PREA Handbook reveals the requisite information identified in this provision is accurately captured at page 7, section entitled Grievance Procedure (c).

The BACS PC asserts there were no residents who reported a sexual abuse incident that occurred at HPRC, at the facility during the on-site audit. Accordingly, the respective interview was not conducted.

Pursuant to the PAQ, the COO 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 COO 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. Zero grievances alleging sexual abuse were filed by residents in the last 12 months in which the resident declined third-party assistance, containing documentation of the resident's decision to decline.

HPRC Policy 4PS entitled Reporting, page 8, section II(D)(2) and (3) address 115.252(e).

The auditor's review of the HPRC PREA Handbook reveals the requisite information identified in this provision is accurately captured at page 7, section entitled Grievance Procedure (d).

Pursuant to the PAQ, the COO 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 COO further self reports agency policy and procedure for emergency grievances alleging substantial risk of imminent sexual abuse requires an initial response within 48 hours. Zero emergency grievances were filed during the last 12 months, alleging substantial risk of imminent sexual abuse. According to the COO, 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 4PS entitled Reporting, page 3, section II(A)(13)(e)(1 and 2) addresses 115.252(f).

The auditor's review of the HPRC PREA Handbook reveals the requisite information identified in this provision is accurately captured at page 8, section entitled Emergency Grievance.

Pursuant to the PAQ, the COO 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 COO further self reports in the last 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 4PS entitled Reporting, page 3, section II(A)(13)(e)(3) addresses 115.252(g).

In view of the above, the auditor finds HPRC substantially compliant with 115.252.

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

HPRC Policy 5PS entitled Medical and Mental Health, pages 1 and 2, section II(B)(1) addresses 115.253(a).

The auditor's review of the HPRC PREA Handbook reveals that the address for Safe Space is not referenced in the Handbook however, the telephone number is referenced on page 4. The address is available pursuant to resident contact with their case manager and the telephone number is referenced on page 4 of the ETC PREA Handbook in the section entitled How to Report an Incident of Sexual

Assault. Additionally, the information is noted on a poster wherein the Safe Space telephone number is referenced.

The auditor recommends the Safe Space telephone number and mailing address be added to the HPRC PREA Handbook on page 9 in the section entitled Counseling Programs for Victims of Sexual Assault and deleted from the aforementioned citation on page 4. Additionally, the address should be added to the poster.

March 4, 2021 Update: The above information has been added to the HPRC PREA Handbook, page 7, under the heading Counseling Programs for Victims of Sexual Assault. Additionally, the recommended information (physical address) has been added to the respective PREA poster.

The auditor's review of the MOU between HPRC and Safe Space reveals substantial compliance with 115.253.

Contact with the BACS PC reveals all in-state calls are free-of-charge, calls are not monitored or recorded, and resident pin numbers/other identifiers are not required for the purpose of making in-state or out-of-state telephone calls.

Six of eight random resident interviewees relate they know there are services available outside of the facility for dealing with sexual abuse, if needed. Three of the eight interviewees identified specific services that are available (counseling, mental health). Seven of the eight interviewees assert addresses and telephone numbers are identified in the PREA Handbook and posted near resident telephones. Seven of eight interviewees assert such telephone calls are free-of-charge. Finally, all eight interviewees assert they can 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.

During the facility tour, the auditor did confirm the requisite telephone number is posted in the vicinity of the resident telephones.

Pursuant to the PAQ, the COO 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 COO 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 5PS entitled Medical and Mental Health, page 2, section II(B)(2and 3) addresses 115.253(b).

Confidentiality is generally addressed on page 9 of the HPRC PREA Handbook entitled Counseling Programs for Victims of Sexual Assault. The auditor notes this provision references only mandatory reporting of sexual abuse that occurred or is occurring at HPRC. The same does not reference reporting of sexual abuse of a minor in the community, alleged sexual abuse in the community, criminal conduct at HPRC and/or in the community, or self-injurious behavior. Additionally, the BACS PC asserts that during the case management intake process, all residents sign a Treatment Confidentiality Agreement. The auditor's review of this form reveals some of the requisite information (as it pertains to

HPRC) is reflected in the document. The auditor finds no evidence the document addresses criminal matters/sexual abuse or child abuse in the community, as well as, self injurious behavior.

Accordingly, the auditor finds HPRC non-compliant with the intent of 115.253(b). In view of the above, a 180-day corrective action period is imposed wherein HPRC will substantiate institutionalization of 115.253(b). The corrective action period will conclude on April 21, 2021.

To substantiate institutionalization, the BACS PC will amend the HPRC PREA Handbook to include the aforementioned subject-matter. Contact with the District Attorney's Office may be prudent for a determination regarding mandatory reporting laws in the State of Montana.

The BACS PC will provide to the auditor a copy of the amended HPRC PREA Handbook. Subsequently, the BACS PC will provide to the auditor a roster reflective of residents received at HPRC since completion and distribution of the amended HPRC PREA Handbook. The auditor will randomly select names, provide the same to the BACS PC, and the PC will provide to the auditor copies of resident receipts for the HPRC PREA Handbook.

February 26, 2021 Update:

The auditor’s review of the amended HPRC PREA Handbook reveals substantial compliance with the aforementioned corrective action. Requisite information is now included on page 7 under the heading Notice to Limits of Confidentiality.

In addition to the above, a document reflecting the names of 20 residents reveals they have been provided the amended HPRC PREA Handbook.

In view of the above, the auditor finds HPRC staff have completed and implemented corrective action as previously described. Accordingly, the auditor finds HPRC substantially compliant with 115.253(b).

Compliance may also be demonstrated by addressing all components of mandatory reporting, as applicable to the subject-matter of 115.253(b), during the PREA Orientation phase. The PC will provide to the auditor the amended lesson plan bearing the referenced subject-matter.

If that option is chosen, the BACS PC will provide to the auditor a copy of a roster reflective of residents received at HPRC since completion and distribution of the amended lesson plan. The auditor will randomly select names, provide the same to the BACS PC, and the PC will provide to the auditor copies of corresponding resident education certifications.

All eight random resident interviewees assert that what they say to people representing the service agencies addressed in the narrative for 115.253(a), remains private. Four of the eight 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, criminal matter at HPRC, and self-injurious behavior. 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 COO 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 COO further self reports the facility maintains copies of these agreements.

The auditor's review of the MOU with Butte Safe Space reveals substantial compliance with 115.253(c).

In view of the above, the auditor finds HPRC substantially compliant with 115.253.

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 COO self reports the agency or 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 on the www.boydandrew.com website. All reports go directly to the BACS PC who, in turn, distributes same to the respective facility.

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 BACS PC 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, name(s) of offender(s) and staff involved, type of incident (sexual abuse, sexual harassment, unknown), facility wherein the offender resides, and the facility wherein the alleged incident occurred, and finally, a description of the alleged incident.

According to the COO, no Third-Party reports have been received during the last 12 months.

In view of the above, the auditor finds HPRC substantially compliant with 115.254.

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

HPRC Policy 4PS entitled Reporting, page 6, section II(C)(1) addresses 115.261(a).

All 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, shift supervisor, BACS PC, or lead security staff.

Pursuant to the PAQ, the COO 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 4PS entitled Reporting, page 6, section II(C)(3) addresses 115.261(b).

HPRC Policy 4PS entitled Reporting, pages 6 and 7, section II(C)(5) addresses 115.261(c).

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. This is driven by their education, HIPPA, policy, Ethics, and Informed Consent. 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 (PD or Deputy Director). Neither interviewee has become personally aware of such incidents during the last 24 months.

HPRC Policy 4PS entitled Reporting, page 6, section II(C)(4) addresses 115.261(d).

As reported to the auditor by the BACS PC, no residents meeting the criteria of the Montana Elder and Persons with Developmental Disabilities Abuse Prevention Act, have been housed at HPRC during the last 12 months. One resident was confined to a wheel chair however, no vulnerable adults have been confined at HPRC during the last 12 months.

According to the PD, juveniles are not housed at HPRC. Nobody under the age of 18 is housed at HPRC. If the need arose with respect to sexual victimization of a vulnerable adult, Adult Protective Services (APS) would be contacted.

The same was again substantiated during the BACS PC's interview. The PC did clarify that vulnerable adults are not generally placed at HPRC as the result of the aforementioned screening process.

HPRC Policy 11PS entitled Coordinated Response/Staff First Responder Duties, page 1, section II(1 and 2) addresses 115.261(e).

According to the PD, he is a PREA Investigator. Reports would come directly to him and he would either initiate an investigation or delegate the same to one of the other trained investigators.

In view of the above, the auditor finds HPRC substantially compliant with 115.261.

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*)

Pursuant to the PAQ, the COO 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 without unreasonable delay. The COO further self reports in the last 12 months, the facility has not determined a resident was subject to substantial risk of imminent sexual abuse.

HPRC Policy 4PS entitled Reporting, page 2, section Procedure A(7) addresses 115.262(a).

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, along with provision of emotional support. The resident will be removed to a safe place and the shift supervisor will be notified to intensify rounds.

In response to a similar question, the PD asserts the potential victim will be placed in a safe place and an attempt is made to identify potential perpetrator(s). Action(s) are initiated immediately.

All 12 random staff interviewees assert that if it is learned a resident is at risk of imminent sexual abuse, the potential victim is immediately removed from harm's way and generally monitored while the matter is reported and documented.

In view of the above, the auditor finds HPRC substantially compliant with 115.262.

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

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 COO 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 COO further self reports there was one allegation received during the last 12 months, wherein a resident was allegedly sexually abused while confined at another facility.

HPRC policy 4PS entitled Reporting, page 7, section II(C)(10) addresses 115.263(a).

The auditor notes the above policy clearly reflects the 115.263(a) reports also apply to allegations of sexual harassment. The auditor finds the same exceeds 115.263(a) as the same pertains only to incidents of sexual abuse. Accordingly, HPRC exceeds standard expectations regarding 115.263.

The auditor's review of an email and report dated January 17, 2020 from the HPRC PD to the Warden at Montana State Prison (MSP) reveals substantial compliance with 115.263(a), (b), and (c). The report was handled in a timely manner and a written record was maintained.

Pursuant to the PAQ, the COO 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.

HPRC policy 4PS entitled Reporting, page 7, section II(C)(10) addresses 115.263(b).

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

HPRC policy 4PS entitled Reporting, page 7, section II(C)(10) addresses 115.263(c).

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

HPRC policy 4PS entitled Reporting, page 7, section II(C)(10) addresses 115.263(d).

The auditor's review of the two notifications of sexual abuse/harassment originating at HPRC reveals the incidents were investigated in a timely manner and a determination of unsubstantiated was made in both matters. Both incidents were forwarded to HPRC from the Warden at MSP.

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 BACS CEO advises such report would be directed to the PD. He/she would communicate with the head of the affected agency. If the incident occurred at our facility, the investigation would be initiated at HPRC. Two 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 immediately initiated. The alleged victim resident would be interviewed at his current facility. The PD would report his findings to the Warden of the current institution upon conclusion of the investigation and findings would subsequently be reported to MDOC.

The PD further asserts two such allegations were received during 2019.

In view of the above, the auditor finds that HPRC exceeds standard requirements for 115.263.

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 COO self reports the agency has a first responder policy for allegations of sexual abuse. The COO further self reports the agency policy requires that, upon learning of an allegation 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 last 12 months, there were four allegations of resident sexual abuse at HPRC. Of these allegations, there were no instances wherein a security staff member was the first responder and he/she separated the alleged victim and abuser. There were no instances wherein staff were notified within a time period that still allowed for the collection of physical evidence.

HPRC Policy 11PS entitled Coordinated Response/Staff First Response Duties, pages 1 and 2, section II(A)(1)(a-m) addresses 115.264(a). In addition to the above, the auditor's review of the HPRC Coordinated Response to PREA Incidents flow chart provides further evidence of compliance with 115.264(a).

The BACS PC asserts three allegations pertained to one staff member. None of the reports were articulated in a time frame wherein the victim and perpetrator were separated, the crime scene was secured, staff requested the victim not destroy physical evidence and staff ensured the perpetrator did not destroy physical evidence.

The security staff first responder interviewee correctly identified the four steps of the first responder protocol while the non-security staff interviewee correctly identified three steps.

Pursuant to the PAQ, the COO self reports agency policy requires that if the first staff responder is not a security staff member, they will facilitate the same first responder duties as articulated in 115.264(a). Two of the four allegations of sexual abuse during the last 18 months were reported to non-security staff. A discussion of the first responder steps taken by recipients of the reports is clearly articulated in the narrative for 115.264(a).

HPRC Policy 11PS entitled Coordinated Response/Staff First Response Duties, page 1, section II(A)(1)(a-m) addresses 115.264(b). The auditor finds that all HPRC security and non-security staff are provided the same first responder training, both pre-service and in-service.

All 12 random staff interviewees assert they know and understand the agency's protocol for obtaining usable physical evidence if a resident alleges sexual abuse. Ten of the 12 interviewees responded appropriately to all four requirements of the uniform evidence protocol, ensuring maximization of the potential for obtaining usable physical evidence.

In view of the above, the auditor finds HPRC substantially compliant with 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 COO 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.

HPRC Policy 11PS 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.

In addition to the above, the auditor's review of the HPRC Coordinated Response to PREA Incidents flow chart provides further evidence of compliance with 115.265(a).

The PD asserts that a plan is in place to coordinate actions among 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.

In view of the above, the auditor finds HPRC substantially compliant with 115.265.

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? X□ Yes □ No

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 COO self reports the facility is not engaged in any collective bargaining agreements with any entity. Accordingly, the auditor has determined 115.266(a) is not applicable to HPRC however, since there are no deviations from standard, HPRC is compliant with the same.

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 COO 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 COO further self reports the agency designates staff member(s) or charges department(s) with monitoring for possible retaliation. Pursuant to HPRC Policy 9PS, the PD and Grievance Coordinator are designated as the staff responsible for retaliation monitoring.

HPRC Policy 9PS entitled Findings, Sanctions, and False Reporting, pages 3 and 4, section II(J)(1-4) addresses 115.267(a).

The auditor's review of one investigation related to a resident who cooperated in an investigation of an alleged sexual abuse incident reveals substantial compliance with 115.267(a). While the information provided by the resident did not pertain directly to an incident of sexual abuse, the same did factor into the "big picture" of an alleged sexual abuse.

The auditor's review of HPRC PREA Incident Follow-up Review Forms reveals weekly contacts, with the exception of one week, were properly facilitated for a 90-day period. Based on the auditor's limited review, it has been determined there is substantial compliance with 115.267.

With respect to one additional investigation, the same was ultimately handled as a staff disciplinary matter most like sexual harassment. Finally, the victim of an unsubstantiated sexual abuse incident was discharged from the facility and 90-day retaliation monitoring was not facilitated.

HPRC Policy 9PS entitled Findings, Sanctions, and False Reporting, pages 3 and 4, sections II(J)(2) and (4) addresses 115.267(b).

In addition to the above, HPRC Policy 10PS entitled Investigations, page 1, section II(A)(1)(c) addresses 115.267(b).

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 with frequent check-ins and immediate Medical/Mental Health support would be invoked. If the victim requests, the Montana Department of Corrections (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. the Employee Assistance Program (EAP) might be recommended.

In regard to strategies available for implementation to protect residents and staff from retaliation in response to reporting sexual abuse and sexual harassment, the PD/designated staff member charged with monitoring retaliation asserts there is zero tolerance for such retaliation. He retains control over housing area changes, imposition of staff disciplinary actions, programming changes, and provision of mental health assistance to residents. He may change a resident's housing status within the facility or request movement to another facility, if appropriate however, the alleged abuser(s), if known, are immediately removed from the facility. Recommendations for EAP and FMLA for staff victims of retaliation and emotional support for resident victims, either on-site or off-site, are viable strategies for implementation.

In regard to measures taken to protect affected residents and staff from retaliation, the interviewee asserts he checks-in with staff or resident victims regarding additional needed changes, etc. He first evaluates the need for alternative housing placement, as referenced in the preceding paragraph.

Additional monitoring of resident victims may be employed. Changing staff duties or shift location(s) for staff victims may be a viable alternative.

The interviewee asserts he does initiate contact with residents who have reported sexual abuse. He checks-in with them weekly thereafter.

Pursuant to the PAQ, the COO 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 COO 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 retaliation.

The COO asserts the facility continues such monitoring beyond 90 days if the initial monitoring indicates a continuing need. There has been no incidents of retaliation within the last 12 months.

HPRC Policy 9PS entitled Findings, Sanctions, and False Reporting, page 3 and 4, section II(J)(3)(a-d) addresses 115.267(c).

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

According to the staff member charged with monitoring retaliation, he evaluates behavioral changes in regard to resident victims (increase in disciplinary history, isolation, hygiene changes, changes in associations and interactions within the facility). In regard to staff victims, accrual of disciplinary infractions, poor job performance, and excessive call-offs are key indicators of possible retaliation.

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.

HPRC Policy 9PS entitled Findings, Sanctions, and False Reporting, pages 3 and 4, section II(J)(3)(a) addresses 115.267(d).

HPRC Policy 9PS entitled Findings, Sanctions, and False Reporting, pages 3 and 4, section II(J)(1-3) addresses 115.267(e).

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

In view of the above, the auditor finds HPRC substantially compliant with 115.267.

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 COO self reports the facility has a policy related to criminal and administrative agency investigations.

HPRC Policy 10PS entitled Investigation, page 1, section I addresses 115.271(a).

According to the investigative staff interviewee, investigations are ordinarily immediately initiated during regular business hours. During non-regular business hours, the PD would respond to the facility in response to a sexual abuse allegation. He may not respond to the facility in the event of a sexual harassment allegation based on a review of circumstances however, he would communicate steps to

be taken with the shift supervisor. The interviewee asserts his reporting time to the facility is 15 minutes.

In regard to anonymous or third-party reports of sexual abuse/harassment, they are investigated in the same manner as any other allegation.

The auditor's on-site review of five random sexual abuse/harassment investigations reveals substantial compliance with 115.271. Investigations were conducted in a timely, thorough, and objective manner.

HPRC Policy 10PS entitled Investigation, 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 uses the PD, the BACS PC, and two security supervisor to investigate administrative cases.

PREA investigative training is described in detail in the narrative for 115.234(a).

According to the investigative staff interviewee, she completed the NIC course (Basic- Conducting Sexual Abuse Investigations in a Confinement Setting). The basic course was a three hour on-line course which included case scenarios.

HPRC Policy 10PS entitled Investigation, page 2, section II(C)(3) addresses 115.271(c).

According to the investigative staff interviewee, first investigative steps would include

Check the crime scene to ensure the same is secured. If the incident appears to be sexual abuse, ensure HPD has been contacted and they are in route (5 minutes);
Speak with victim, asking threshold questions (15-30 minutes);
Review staff and resident reports (5 minutes);
Interview staff and resident witnesses, documenting findings (0-2 hours);
Review video footage and files to establish any validation (10 minutes to 2 hours);
If administrative investigation, interview the perpetrator, if known (0-60 minutes);
Re-interview victim, witnesses, and perpetrator to establish credibility (10 minutes to 2 hours); and
Write report (1 hour).

The interviewee asserts she collects relevant video footage, staff/resident reports, interview notes, photographs, and logs for use during the investigation.

HPRC Policy 10PS entitled Investigation, Page 1, 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 staff interviewee, compelled interviews are not facilitated at HPRC by HPRC PREA Investigators. Prosecution referral and the conduct of compelled interviews falls under the purview of HPD.

HPRC Policy 10PS entitled Investigation, page 2, section II(C)(4) and (5) addresses 115.271(e).

The investigative interviewee 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 the totality of circumstances.

The interviewee further asserts criminal investigations are not conducted by HPRC PREA investigators. 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 10PS entitled Investigation, page 1, sections II(A)(1)(a and b) addresses 115.271(f).

To assess and determine whether staff actions or failures to act contributed to the sexual abuse, the investigative staff interviewee advises cameras are reviewed to determine if rounds were efficient or inefficient. Is/was the camera system operational? Additionally, what did staff know or should they have known? Is there any evidence of neglect? Staff files are also checked to determine any history of neglect.

All of the above is subsequently assessed against the Code of Conduct, ethics, and potential policy violations.

The investigative staff interviewee asserts that administrative investigation findings are documented in a written report. Reports include the following:

Historical data;
Interview results, inclusive of credibility assessments;
Assessment of any physical evidence observed at the scene;
Camera reviews;
File reviews;
Timeline regarding the chain of events and the investigative process;
Findings; and
Conclusion.

HPRC Policy 10PS entitled Investigation, page 2, section II(C)(6) addresses 115.271(g).

The investigative staff interviewee asserts 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). The interviewee asserts criminal investigation referrals are documented.

The BACS PC asserts HPD does not provide copies of criminal investigations to the facility. Of note, none of the resident victims were confined at HPRC when the criminal investigations were conducted and likewise, the offending employee's employment was terminated for reasons unrelated to the investigations.

Pursuant to the PAQ, the COO self reports substantiated allegations of conduct that appear to be criminal are referred for prosecution. The COO further self reports there were no allegations of conduct that appear to be criminal that were referred for prosecution since the last PREA audit.

The investigative staff interviewee asserts she 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 COO 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 10PS entitled Investigations, page 2, section II(D) addresses 115.271(i).

The auditor has found no inconsistency with either policy or 115.271(i).

HPRC Policy 10PS entitled Investigation, page 1, section I addresses 115.271(j).

The PREA Investigative staff interviewee asserts the investigation continues when a staff member alleged to have committed sexual abuse terminates employment prior to a completed investigation into his/her conduct. The results of the investigation are documented in the HR file. The same premise is true when a resident victim who alleges sexual abuse/harassment or an alleged resident abuser leaves the facility prior to a completed investigation into the incident.

HPRC Policy 10PS entitled Investigation, page 2, section II(C)(2) addresses 115.271(l).

According to the PD, in the event an outside agency investigated allegation(s) of sexual abuse, HPD investigator(s) generally stay in contact with him. Actually, he would attempt to stay in contact with HPD investigator(s) on a frequent basis pursuant to email or telephonic conversations.

The BACS PC essentially corroborates the PD's statement as she asserts there would be frequent contact between the PD and HPD investigator(s). As previously stated, the PD is one of the facility PREA investigators.

The investigative staff interviewee asserts, in terms of her role with outside investigators conducting a sexual abuse investigation, she is the point of contact, acting as a facilitator and liaison in conjunction with the criminal investigation.

In view of the above, the auditor finds HPRC substantially compliant with 115.271.

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 COO 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 10PS entitled Investigations, page 3, section II(E) addresses 115.272(a).

The auditor's review of investigations referenced throughout the narrative if 115.271, as well as, on-site review of investigations reveals substantial compliance with 115.272(a).

The investigative staff interviewee describes the requisite administrative standard of proof (preponderance of evidence) as "there is more evidence that it happened, than not.”

In view of the above, the auditor finds HPRC substantially compliant with 115.272.

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 the agency's facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) 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

☐ **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 COO self reports the agency has a policy requiring that any resident who makes an allegation 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 COO further self reports the agency completed five administrative investigations of alleged resident sexual abuse during the last 12 months.

Of note, one of the five investigations (most like sexual harassment) was ultimately handled as a staff disciplinary matter. Additionally, during random investigative file reviews of incidents that occurred during the last 12 months, the auditor determined four cases actually constituted sexual harassment, inclusive of the matter that was handled as a staff disciplinary case.

Three additional criminal investigations of sexual abuse were completed by HPD during the last 12 months.

According to the BACS PC, none of the eight victims were apprised regarding the investigative outcome in accordance with 115.273(a).

HPRC Policy 10PS entitled Investigations, pages 2 and 3, section III(A) addresses 115.273(a). The auditor notes 115.273(a) notifications to the resident pertain to both sexual abuse and sexual harassment according to the aforementioned policy.

The BACS PC asserts the three allegations against a staff member were determined to constitute sexual abuse. The remaining five allegations were determined to be sexual harassment. The five sexual harassment allegations were handled as administrative investigations while the three sexual abuse allegations were criminally investigated. Five of the alleged victims had been released from HPRC and accordingly, written notification was not required.

One sexual harassment investigation was determined to be unfounded however, the 115.273(a) notification was not provided and with respect to one additional investigation, the requisite 115.273(a) notification was not provided.

In view of the above, the lack of notifications relative to two sexual harassment investigations applicable to 115.273(a), have been determined to be non-compliant based on lack of compliance with policy. Accordingly, the auditor finds HPRC non-compliant with 115.273(a).

The auditor is imposing a 180-day corrective action period wherein HPRC will demonstrate institutionalization of 115.273(a) notification requirements. The corrective action period will end on or about April 30, 2021.

To demonstrate compliance with 115.273(a), the BACS PC will provide specific training to stakeholders regarding each tenet of 115.273. A copy of the training plan will be provided to the auditor, as well as, training documentation substantiating stakeholder completion of the same.

In addition to the above, the BACS PC will provide to the auditor copies of each investigation conducted between the date of this report and the aforementioned date, inclusive of 115.273(a) notifications, as applicable. The auditor will include the same in the audit file and he will subsequently evaluate compliance.

February 4, 2021 Update:

The auditor's review of a mock sexual abuse scenario (inclusive of the investigation/Resident Notification of Investigation Outcome, and Sexual Assault Response Team (SART) Report) reveals substantial compliance with 115.273(a) and 115.286(c) requirements. Specifically, following conclusion of the mock investigation, the victim was notified, in a timely manner, of the investigation results. The SART review was also completed in a timely and comprehensive manner and the same was documented.

The auditor notes that in view of the lack of investigations, notifications, and SART Reports since completion of the Interim PREA Audit Report, he agreed to implementation of a mock scenario as corrective action.

February 19, 2021 Update:

The auditor's review of three Staff Development and Training Record Forms related to provision of requisite training regarding 115.273(a) requirements reveals three stakeholders completed and understand the same. The training was completed on February 9, 2021 and February 11, 2021. The auditor's review of the lesson plan reveals substantial compliance with 115.273(a).

In view of the above, the auditor now finds HPRC substantially compliant with 115.273.

According to the PD, the facility does notify a resident who makes an allegation of sexual abuse/ harassment when the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation. The investigator is responsible for making such notification.

The investigative staff interviewee asserts agency procedure requires that a resident who makes an allegation of sexual abuse/harassment must be informed as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation. The investigator makes the notification.

Pursuant to the PAQ, the COO 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), three criminal investigations of facility sexual abuse were conducted in the last 12 months. However, the COO self reports no notifications regarding the dispositions for criminal sexual abuse investigations were issued to affected residents during the last 12 months.

The auditor's review of several emails from the PD to the HPD investigator reveals substantial compliance with 115.273(b). In view of the above, the auditor finds HPRC compliant with the intent of 115.273(b).

Pursuant to the PAQ, the COO 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 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 COO further self reports there has been three 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 last 12 months. Pursuant to the PAQ, the COO self reports the above notifications were not made in any of these cases.

HPRC Policy 10PS entitled Investigations, page 3, section III(C)(1-4) addresses 115.273(c).

As mentioned in the narrative for 115.273(a), the victims of staff sexual abuse were no longer confined at HPRC upon conclusion of the investigation. Accordingly, 115.273(c) notification was not required.

Pursuant to the PAQ, the COO 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 10PS entitled Investigations, page 3, section III(D)(1 and 2) addresses 115.273(d).

The BACS PC asserts zero 115.273(d) notifications have been made during the last 12 months as there were zero allegations of resident-on-resident sexual abuse during the time period.

Pursuant to the PAQ, the COO self reports the agency has a policy that all notifications to residents described under this standard are documented. As previously indicated, zero notifications pursuant to 115.273(a-d) were effected during the last 12 months and accordingly, there is no documentation validating notifications.

HPRC Policy 10PS entitled Investigations, page 3, section III(E) addresses 115.273(e).

In view of the above, the auditor finds HPRC non-compliant with 115.273(e). 115.273(a) corrective action is likewise applicable to 115.273(e).

In view of the above, the auditor finds HPRC substantially compliant with 115.273.

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 COO self reports staff is subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

HPRC Policy 9PS entitled Findings, Sanctions, and False Reporting, page 2, section II(H) addresses 115.276(a).

The BACS PC asserts the employment of the staff perpetrator in the aforementioned sexual abuse cases was terminated prior to completion of the criminal investigation. The termination was predicated upon eight administrative charges not directly related to the sexual abuse case.

Pursuant to the PAQ, the COO self reports with the exception of the above criminal allegations, zero facility staff violated agency sexual abuse/harassment policies during the last 12 months.

HPRC Policy 9PS entitled Findings, Sanctions, and False Reporting, page 2, section II(H)(1) addresses 115.276(b).

Pursuant to the PAQ, the COO 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 COO further self reports in the last 12 months, one staff member from the facility has been disciplined, short of termination, for violation of agency sexual abuse or sexual harassment policies.

The auditor notes that, as previously referenced, one staff member who was named in the three criminal matters, was terminated from employment prior to conclusion of the investigation, based on matters separate from any sexual abuse. The BACS PC asserts another staff member was disciplined for sexual harassment related conduct. The auditor's review of the disciplinary letter reveals substantial compliance with 115.276(c). Accordingly, the auditor's findings validate assertions by the COO.

In the latter matter, the staff disciplinary letter was based on an incident of sexual harassment, resulting in suspension and demotion for a code of conduct issue. The employee resigned as the result and his verbal resignation was accepted on the spot.

HPRC Policy 9PS entitled Findings, Sanctions, and False Reporting, page 2, 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 COO 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 COO further self reports in the last 12 months, one facility staff member was referred to law enforcement prior to employment termination. Referral to a licensing board was not applicable in that matter and referral to either with respect to the sexual harassment matter, was not applicable given the circumstances of the incident and the perpetrator's scope of responsibilities.

HPRC Policy 9PS entitled Findings, Sanctions, and False Reporting, page 3, section II(H)(3) addresses 115.276(d).

In view of the above, the auditor finds HPRC substantially compliant with 115.276.

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 COO self reports agency policy requires that any contractor or volunteer who engages in sexual abuse is reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. The COO further self reports agency policy requires that any contractor or volunteer who engages in sexual abuse is prohibited from contact with residents.

In the last 12 months, no contractors or volunteers were reported to law enforcement agencies and relevant licensing bodies for engaging in sexual abuse of residents. The COO further asserts there were no allegations of sexual abuse lodged against contractors or volunteers during the last 12 months.

HPRC Policy 9PS entitled Findings, Sanctions, and False Reporting, page 3, section II(I)(1) addresses 115.277(a).

Pursuant to the PAQ, the COO 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 9PS entitled Findings, Sanctions, and False Reporting, page 3, section II(I)(2) addresses 115.277(b).

The PD asserts that in the case of any violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, access privileges are temporarily rescinded pending the outcome of an investigation.

In view of the above, the auditor finds HPRC substantially compliant with 115.277.

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? X□ Yes □ No

115.278 (e)

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? 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)

- If the agency prohibits all sexual activity between residents, does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.) 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 COO 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 COO 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 COO, there were no substantiated administrative findings of resident-on-resident sexual abuse that occurred at the facility during the last 12 months. The COO further self reports there were no substantiated criminal findings of resident-on-resident sexual abuse that occurred at the facility during the last 12 months.

HPRC Policy 9PS entitled Findings, Sanctions, and False Reporting, page 1, section II(C) addresses 115.278(a).

HPRC Policy 9PS entitled Findings, Sanctions, and False Reporting, pages 1 and 2, section II(C)(1-3) address 115.278(b).

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 prosecution and transfer to a secure facility/recommended removal from the HPRC program. The resident would be removed from the program pending review of the recommendation.

MDOC staff conduct a disciplinary hearing for major violations and impose sanctions accordingly. Assurance that sanctions are 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, falls under the purview of MDOC. Similarly, consideration of whether a resident's mental disabilities or mental illness contributed to the behavior, when determining a sanction, likewise falls under the purview of 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.

HPRC Policy 9PS entitled Findings, Sanctions, and False Reporting, page 2, section D(1) generally addresses 115.278(c).

The auditor has determined that MDOC staff conduct administrative misconduct hearings for major rule violations pursuant to contract with HPRC. Accordingly, HPRC plays no role in terms of the conduct of such hearings. However, HPRC staff conduct hearings for minor rule violations and accordingly, they consider 115.278 requirements.

While 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, the following does generically address 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.

Pursuant to the PAQ, the COO self reports the facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse. The COO 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 9PS entitled Findings, Sanctions, and False Reporting, page 2, section II(D)(1-3) addresses 115.278(d).

According to the Mental Health interviewee, consideration 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) would occur. 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 COO 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 9PS entitled Findings, Sanctions, and False Reporting, page 2, section II(G) addresses 115.278(e).

The BACS PC asserts zero residents have been disciplined for sexual contact with staff during the last 12 months.

Pursuant to the PAQ, the COO 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 9PS entitled Findings, Sanctions, and False Reporting, page 2, section II(E) addresses 115.278(f).

Pursuant to the PAQ, the COO self reports the agency prohibits all sexual activity between residents. The COO 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 9PS entitled Findings, Sanctions, and False Reporting, pages 2, section II(F) addresses 115.278(g).

In view of the above, the auditor finds HPRC substantially compliant with 115.278.

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 COO self reports resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The COO 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., form, log) 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 zero sexual abuse incidents invoked such medical procedures during the last 12 months, no completed documents have been 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.

The COO 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., form, log) 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.

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 and based on the situation. The nature and scope of these services would be initially determined according to their professional judgment if summoned to the facility or they render attention during their work hours however, if the victim is transferred to a hospital, medical judgment becomes the purview of the hospital provider(s).

HPRC Policy 11PS entitled Coordinated Response/Staff First Response Duties, pages 1 and 2, sections II(A)(1)(a-m) addresses 115.282(b).

The security staff first responder interviewee correctly identified the four steps of the first responder protocol while the non-security staff interviewee correctly identified three steps. A more in-depth discussion regarding first responder steps is articulated in the narrative for 115.264.

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.

Pursuant to the PAQ, the COO 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 COO further self reports medical and mental health staff maintain secondary materials (e.g., form, log) 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 auditor's review of a letter from the provider of forensic examinations reveals substantial compliance with 115.282(c).

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 this information is provided as part of the forensic examination and the same is verified pursuant to the SANE interview referenced in the narrative for 115.221(c).

Pursuant to the PAQ, the COO 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 5PS entitled Medical and Mental Health, page 2, section II(C)(3) addresses 115.282(d).

In view of the above, the auditor finds HPRC substantially compliant with 115.282.

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. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) □ Yes □ No 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. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) □ Yes □ No 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 COO 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 5PS entitled Medical and Mental Health, page 2, section II(C) and (1) addresses 115.283(a).

According to the BACS PC, residents who report sexual abuse at another confinement facility are offered mental health care and they have the option to deny the same. Within the last 24 months, one resident who reported sexual abuse in another facility declined mental health intervention subsequent to reporting sexual abuse that occurred at another facility. The auditor's review of the HPRC Mental Health Review Form relating to this resident reveals he did decline the mental health meeting.

The PC further asserts affected residents are offered a meeting with a mental health practitioner which would occur within 14 days of the report. The case manager facilitates the referral for such meetings, either in-house or in the community based on the resident's preference.

HPRC Policy 5PS entitled Medical and Mental Health, page 2, section II(C)(1) addresses 115.283(b).

According to the medical staff interviewee, evaluation and treatment of residents who have been victimized would entail keeping them calm. Provide emotional support and secure vitals, if possible. If bleeding/bruising is noted, stabilize them. Follow-up treatment plans are dictated by hospital practitioners.

The mental health interviewee asserts she would determine what happened during the event. Assess family systems issues, mental health condition(s), and educational history. She would primarily provide support and empathy.

The BACS PC asserts that during the last 24 months, zero residents, as described in 115.283(b), have been released from custody and requisite materials followed them.

HPRC Policy 5PS entitled Medical and Mental Health, page 2, section II(C)(2) addresses 115.283(c).

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 or if the incident occurred while they were on-duty. At any rate, care would be transferred to a community hospital for SAFE/SANE examination and any follow-up care.

HPRC is a male only facility and accordingly, the auditor has determined that 115.283(d) is not applicable to HPRC.

HPRC is a male only facility and accordingly, the auditor has determined that 115.283(e) is not applicable to HPRC.

Pursuant to the PAQ, the COO self reports resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate.

HPRC Policy 5PS entitled Medical and Mental Health, page 3, section II(C)(4) addresses 115.283(f).

Pursuant to the PAQ, the COO 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 5PS entitled Medical and Mental Health, page 3, section II(C)(4) addresses 115.283(g).

As reflected throughout this report, zero residents who reported a sexual abuse incident were housed at HPRC during the on-site audit.

Pursuant to the PAQ, the COO 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 5PS entitled Medical and Mental Health, page 3, section II(C)(5) addresses 115.283(h).

The BACS PC asserts during the last 24 months, HPRC has not received any known resident-on-resident abusers.

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.

The interviewee further asserts zero resident-on-resident sexual abusers have been housed at HPRC during the last 12 months.

In view of the above, the auditor finds HPRC substantially compliant with 115.283.

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

☐ **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 COO self reports the facility conducts a sexual abuse incident review at the conclusion of every criminal or administrative sexual abuse/harassment investigation, unless the allegation has been determined to be unfounded. The COO further self reports in the last 12 months, seven criminal and/or administrative investigations of alleged sexual abuse/harassment were completed at the facility, excluding only "unfounded" incidents.

HPRC Policy 7PS entitled Data Collection, Aggregation, Review and Audit, page 1, section II(A)(1) addresses 115.286(a).

The auditor's review of four HPRC SART Checklists (conducted within the last 14 months) reveals the date of investigation completion is absent in two reports and accordingly, a determination regarding timeliness cannot be made. Additionally, one review was facilitated outside the ordinary 30-day window from investigation conclusion. The review team members are determined to be sufficient and all other tenets of 115.286(d) are met.

The auditor finds HPRC substantially compliant with 115.286(a) and (b) as three of the four mentioned SART reviews were conducted in a timely manner. However, as the standard clearly specifies, reviews are "ordinarily" completed within 30 days of completion of the investigation, the auditor finds that in the one aforementioned case, the same does not equate to a finding of non-compliance. However, as referenced above, the auditor notes the failure to document the date the investigation was completed in two cases. **Going forward, this must be corrected for purposes of analyzing timeliness of SART reviews pursuant to 115.286(b).**

Pursuant to the PAQ, the COO self reports the facility ordinarily conducts a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse/harassment investigation. The COO further self reports in the last 12 months, three criminal and/or administrative investigations of alleged sexual abuse/harassment were completed at HPRC followed by a sexual abuse incident review within 30 days of conclusion of the investigation.

HPRC Policy 3.7 entitled Data Collection, Aggregation, Review and Audit, page 1, section II(A)(1)(b) addresses 115.286(b).

Pursuant to the PAQ, the COO 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, Review and Audit, page 1, section II(A)(1)(c) addresses 115.286(c).

The PD asserts the aforementioned 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 aforementioned SART review participants were the PD, BACS PC, mental health and/or 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 asserts 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(s) noted above.

Pursuant to the PAQ, the COO 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 7PS entitled Data Collection, Aggregation, Review and Audit, pages 1 and 2, section II(A)(1)(d) addresses 115.286(d).

The aforementioned HPRC SART Checklist addresses all of the requisite components of 115.286(d) and the same were adequately addressed with known facts and observations.

With the exception of the missing date entries mentioned in the narrative for 115.286(a), the auditor's review of the four previously mentioned HPRC SART Checklists reveals substantial compliance with 115.286(d). The auditor notes the BACS PC reviewed and signed for the same in three of the four cases mentioned above.

The PD asserts the SART considers staffing plan viability, camera placements, and assesses, if any, whether improvements (policy, procedure, training) are warranted. The questions of "What did we did right and what did we do wrong" are answered. Requests for funding may result from the SART review.

The PD also stated the SART:

(1) Considers whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse;
(2) Considers 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) Examines the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;
(4) Assesses the adequacy of staffing levels in that area during different shifts; and
(5) Assesses whether monitoring technology should be deployed or augmented to supplement supervision by staff.

A report is compiled addressing the above and any recommendations for improvement with the same, submitted to the PD and BACS PC.

The SART interviewee also confirmed these issues are considered during the SART review.

The BACS PC 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 BACS PC and she is routinely involved in SART reviews. The auditor notes the BACS PC received the report in three of the four cases.

No trends have been identified. If deficiencies are identified subsequent to the PREA Coordinator's review or participation in the SART, she makes recommendations and discusses the same with the PD.

Pursuant to the PAQ, the COO self reports the facility implements the recommendations for improvement or documents its reasons for not doing so.

HPRC Policy 7PS entitled Data Collection, Aggregation, and Review, page 2, section II(A)(1)(e) addresses 115.286(e).

The BACS PC asserts that in some cases, SART recommendations have not been completed or followed and the rationale for the same has not been documented.

The auditor's review of the aforementioned four SART Checklists [as referenced in 115.286(a)] reveals in one case, part of the recommended corrective action was documented on the report as completed. However, the auditor has not been provided any further evidence substantiating completion of the remaining corrective action or the documented basis for non-implementation.

In view of the above, the auditor finds HPRC non-compliant with 115.286(e). Accordingly, a 180-day corrective action period is imposed with a completion date of April 30, 2021.

To demonstrate compliance with 115.286(e), the BACS PC will provide training to all SART members regarding the nuances of 115.286, inclusive of 115.286(e). The BACS PC will provide to the auditor a copy of the training plan, as well as, training documentation substantiating provision of the training to stakeholders.

In addition to the above, the BACS PC will forward to the auditor any and all SART reports completed between the dates of completion of this report and the completion date for corrective action, wherein recommendations are articulated. Evidence of completion of the recommendation or the documented reason for non-implementation of recommended corrective action, will likewise be forwarded to the auditor.

February 4, 2021 Update:

The auditor’s review of a mock sexual abuse scenario (inclusive of the investigation/Resident Notification of Investigation Outcome, and Sexual Assault Response Team (SART) Report) reveals substantial compliance with 115.273(a) and 115.286(c) requirements. Specifically, following conclusion of the mock investigation, the victim was notified, in a timely manner, of the investigation results. The SART review was also completed in a timely and comprehensive manner and the same was documented.

The auditor notes that in view of the lack of investigations, notifications, and SART Reports since completion of the Interim PREA Audit Report, he agreed to implementation of a mock scenario as corrective action.

February 19, 2021 Update:

The auditor’s review of three Staff Development and Training Record Forms related to provision of requisite training regarding 115.286 requirements reveals three stakeholders completed and understand the same. The training was completed on February 9, 2021 and February 11, 2021. The auditor’s review of the lesson plan reveals substantial compliance with 115.286.

In view of the above, the auditor now finds HPRC substantially compliant with 115.286.

The auditor recommends that a copy of the above evidence be maintained in the HPRC investigative file to ensure quick and easy retrieval. If this practice is in effect, the same is moot.

In view of the above, the auditor finds HPRC non-compliant with 115.286.

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 COO 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 COO 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 7PS entitled Data Collection, Aggregation, Review and Audit, page 2, section II(A)(2)(a-k) addresses 115.287(a)/(c).

The auditor reviewed a statistical compilation document entitled 2019 Annual PREA Statistical Report, finding the same to meet the majority of criteria required by 115.287(a)/(c).

According to the BACS PC, SSVs have not been requested for 2018 and 2019.

Pursuant to the PAQ, the COO self reports the agency aggregates the incident-based sexual abuse data at least annually.

HPRC Policy 7PS entitled Data Collection, Aggregation, Review and Audit, page 3, section II(A)(6) addresses 115.287(b).

The auditor verified the aforementioned statistical compilation documents do reflect annual aggregation.

Pursuant to the PAQ, the COO 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 7PS entitled Data Collection, Aggregation, Review and Audit, page 2, section II(A)(3) addresses 115.287(d).

The auditor's articulation throughout this report regarding documents reviewed serves as substantiation of HPRC compliance with 115.287(d).

Pursuant to the PAQ, the COO 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 COO 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) not applicable to HPRC.

In view of the above, the auditor finds HPRC substantially compliant with 115.287.

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 COO 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 7PS entitled Data Collection, Aggregation, Review and Audit, page 3, section II(B)(s)(1-3) addresses 115.288(a).

The auditor's review of the 2018 and 2019 HPRC Annual PREA Reports reflects a comparison of data from 2014 through 2019 with a recapitulation of findings regarding investigations by year. Additionally, the annual PREA report addresses the annual staffing plan, camera surveillance, policies, and training endeavors. The auditor finds these HPRC PREA annual reports are sufficient as the same 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 guide to enhancing resident sexual safety at HPRC.

According to the BACS PC, she 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. She retains all investigative reports in a locked cabinet in her office. Requisite information is extracted from investigative reports and other sources.

Her 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 BACS PC's office.

The BACS PC asserts annual reports are generated from each individual facility.

It is noted the auditor did observe the aforementioned locked file cabinet in the BACS PC's Office throughout the on-site review.

Pursuant to the PAQ, the COO self reports the annual report includes a comparison of the current year’s data and corrective actions with those from prior years. The COO further self reports the annual report provides an assessment of the agency’s progress in addressing sexual abuse.

As mentioned in the narrative for 115.288(a), each annual report includes demographics for the previous several years, as well as any corrective measures taken.

Pursuant to the PAQ, the COO self reports the agency makes its annual report readily available to the public at least annually through its website. The COO further self reports the annual reports are approved by the agency head.

Pursuant to the auditor's review of the aforementioned HPRC Annual Reports, the BACS PC , HPRC PD, and BACS CEO signed the same. Additionally, the auditor notes the HPRC 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 COO 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. The COO further self reports the agency indicates the nature of the material redacted.

HPRC Policy 7PS entitled Data Collection, Aggregation, Review and Audit, page 3, section II(B)(d) addresses 115.288(d).

The auditor did not find any evidence of redaction in the HPRC Annual Reports.

The BACS PC 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.

In view of the above, the auditor finds HPRC substantially compliant with 115.288.

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 COO self reports the agency ensures that incident-based and aggregate data are securely retained.

HPRC Policy 7PS entitled Data Collection, Aggregation, Review and Audit, page 4, section II(C)(a) addresses 115.289(a).

According to the BACS PC, she 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. She retains all investigative reports in a locked cabinet in her office. Requisite information is extracted from investigative reports and other sources.

Her 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 BACS PC's Office.

In the event corrective actions or recommendations are identified in SART reviews, the same are implemented and if not implemented, the basis for the same is clearly documented.

It is noted the auditor did observe the aforementioned locked file cabinet in the BACS PC's Office throughout the on-site review.

Pursuant to the PAQ, the COO 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 7PS entitled Data Collection, Aggregation, Review and Audit, page 4, section II(C)(b) addresses 115.289(b).

The auditor reviewed the BACS/HPRC website and validated the requisite information is maintained therein.

Pursuant to the PAQ, the COO self reports before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers.

HPRC Policy 7PS entitled Data Collection, Aggregation, Review and Audit, page 4, section II(C)(c) addresses 115.289(c).

The auditor reviewed all aggregated data reflected on the aforementioned website and found no issues relative to personal identifiers being included in any data.

Pursuant to the PAQ, the COO 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 7PS entitled Data Collection, Aggregation, Review and Audit, page 4, section II(C)(4) addresses 115.289(d).

The auditor finds no deviations from either policy or standard in regard to 115.289(d).

In view of the above, the auditor finds HPRC substantially compliant with 115.289.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

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

115.401 (a)

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

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard*.) X□ Yes □ No

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

- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) □ Yes □ No 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 residents? 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 auditor commends HPRC staff relative to their efforts with the on-site audit. Resident and staff interviews were facilitated in a timely manner, resulting in timely completion of the audit.

All components of this standard were handled in a superb fashion, inclusive of Pre-audit questions and documentary needs.

Standard 115.403: Audit contents and findings

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

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) 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*)

None.

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 March 23, 2021

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.