

PREA AUDIT REPORT INTERIM FINAL
JUVENILE FACILITIES

Date of report: September 1, 2017

Auditor Information			
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Telephone number: 979-696-6373			
Date of facility visit: July 24, 2017 to July 26, 2017			
Facility Information			
Facility name: Great Falls Youth Transition Center (YTC)			
Facility physical address: 4212 3rd Ave. S., Great Falls, MT 59405			
Facility mailing address: <i>(if different from above)</i> Click here to enter text.			
Facility telephone number: 406-452-1792			
The facility is:	<input type="checkbox"/> Federal	<input checked="" type="checkbox"/> State	<input type="checkbox"/> County
	<input type="checkbox"/> Military	<input type="checkbox"/> Municipal	<input type="checkbox"/> Private for profit
	<input type="checkbox"/> Private not for profit		
Facility type:	<input checked="" type="checkbox"/> Correctional	<input type="checkbox"/> Detention	<input type="checkbox"/> Other
Name of facility's Chief Executive Officer: Mr. Kenneth McGuire			
Number of staff assigned to the facility in the last 12 months: 14			
Designed facility capacity: 9			
Current population of facility: 7			
Facility security levels/inmate custody levels: Minimum			
Age range of the population: 10-17			
Name of PREA Compliance Manager: Mr. Kenneth McGuire		Title: Program Director	
Email address: kmcguire@mt.gov		Telephone number: 406-452-3216	
Agency Information			
Name of agency: Montana Department of Corrections			
Governing authority or parent agency: <i>(if applicable)</i> Click here to enter text.			
Physical address: 5 S Last Chance Gulch St, Helena, MT 59620			
Mailing address: <i>(if different from above)</i> Click here to enter text.			
Telephone number: 406-444-3930			
Agency Chief Executive Officer			
Name: Reginald Michael		Title: MDOC Director	
Email address: R.Michael@mt.gov		Telephone number: 406-444-3930	
Agency-Wide PREA Coordinator			
Name: Michele Morgenroth		Title: Interim PREA Coordinator	
Email address: MMorgenroth@mt.gov		Telephone number: 406-444-2828	

AUDIT FINDINGS

NARRATIVE

The Montana Department of Corrections (MDOC) requested a PREA Audit for the Great Falls Youth Transition Center (YTC) located in Great Falls, Montana. The pre-audit work began on April 13, 2017 and the onsite portion of the PREA Audit was conducted between July 24, 2017 and July 26, 2017. (NOTE: For the purposes of this PREA Report the term "Agency" always represents the MDOC and the term "Facility" at all times represents Great Falls Youth Transition Center).

The Data Audit Framework used by this Auditor to assess the Agency's and Facility's compliance with the PREA Standards relied on Agency policies, Facility procedures, the Pre-Audit Questionnaire and associated attachments. Further, the Data Audit Framework relied on interviews with 15 staff [nine from the Facility and five (5) from the Agency], seven (7) residents (100.0% of all residents at the facility), a review of 11 client files (including all current residents and four files of former residents, 13 staff files, as well as interviews with local area services providers [local area rape crisis center and local hospitals that would be used for forensic exams]).

DESCRIPTION OF FACILITY CHARACTERISTICS

The Great Falls Youth Transition Center (also known as the Facility) is currently designed to house up to seven-minimum security male residents between the ages of 10 and 17 that have been committed to the MDOC (also known as the Agency). As of the onsite audit there were seven (7) juvenile offenders at the Facility. To accommodate those residents the Facility employees approximately 13 staff positions (eight (8) full-time and five (5) part-time) of which all 13 are considered “security” staff for the purpose of the staff-to-resident ratio as defined by PREA.

The Facility is in a residential neighborhood and is comprised of two main buildings, of which the MDOC has access to one [The other building is owned by the landlord and is not available for use by MDOC]. The main buildings is comprised of four “levels”: (1) Level One, or the basement, contains a bedroom, bathroom, closets, and laundry area; (2) Level Two, or the main living area, is comprised of the kitchen, two large ‘great rooms’ containing televisions, a smaller ‘great room’ that is used for training and socializing, and a staff duty station; (3) Level Three, or the main housing area, contains three bedrooms and one bathroom; and (4) Level Four, or the Administrative Offices, contains the Facility Head’s office, staff duty station, copier and a staff bathroom. In addition, there is one storage shed located outside the main building. Residents are not under constant supervision as residents are allowed, based on earning privileges, the opportunity to go to the corner store or to work at local businesses in the community. Further, the Facility does not have any cameras.

Routine medical care and mental health care is provided offsite. At the time of the onsite audit portion of this PREA Audi there were a total of zero (0) volunteers and contractors authorized to enter the Facility. The Facility has had one previous PREA Audit (Cycle One, Year Three [2016]).

SUMMARY OF AUDIT FINDINGS

Prior to the onsite auditing conducted between July 24, 2017, and July 26, 2017, for this PREA Audit it was confirmed, via photographic email evidence provided by the Facility PREA Compliance Manager (PCM), that the required PREA Audit notice was posted. That evidence confirmed that the notices were posted 42-days in advance and that they were posted in various, conspicuous, areas throughout the Facility.

Starting on June 26, 2017, this Auditor received an overnight package containing the completed Pre-Audit Questionnaire. Upon review of the information and data provided, it became clear that the Facility had taken significant steps toward meeting PREA compliance. A conference call with this Auditor, the Interim PREA Coordinator, and the Facility's Superintendent was conducted on July 11, 2017, and confirmed that the Facility was ready for a PREA compliance audit.

On the first day (July 24, 2017) of onsite auditing an introduction meeting was held at approximately 8:30 AM with the Facility Superintendent and the Interim State PREA Coordinator. It was noted that there were seven (7) male residents on site at the time of the audit. It was also noted that the PREA Coordinator was an interim and that the PCM for the Facility was new to the position and being trained by the previous PCM, which is also the Facility Superintendent. Following this meeting, a tour of the entire Facility was conducted and this Auditor noted the layout of the physical grounds and the various structures. Additionally, notices about this PREA Audit as well as notices regarding the rights of the residents to be free from sexual abuse and sexual harassment were observed. These notices included information on how residents could report sexual abuse and sexual harassment. During this tour, it was noted that previous "blind spots" were removed by adding a physical barrier.

During this tour, this Auditor observed residents being supervised by the Facility Staff (i.e., security staff) but that residents' who have earned privileges could exit the facility with approval. Further, it was observed that in the Facility there were staff of both genders present. It was noted in the housing unit that a ratio of 1:8 was being maintained. During the onsite audit, this Auditor formally interviewed seven of the seven residents, meaning that 100.0% of the total facility resident population was interviewed as part of the onsite audit

As part of the routine work during the onsite portion of this PREA Audit, this Auditor interviewed a total of 15 staff, including security, administrators, and specialized staff. Nine of the 15-interviewed staff were security staff and represented security staff from all shifts and all facility units. This auditor interviewed 100.0% of all full-time staff and 20.0% of all part-time staff. The remaining part-time staff could not be reached by the facility during the onsite audit.

After the onsite portion of this PREA Audit, it was determined that the Facility "Exceed Standard" on one PREA Standard (115.351); "Meets Standard" on 36 PREA Standards, "Did Not Meet Standard" on one PREA Standard (115.317) while three PREA Standards (115.318; 115.332; and 115.335) were deemed "Not Applicable." The facility entered a Corrective Action Plan (CAP) period on August 18, 2017 and exited the CAP period on August 29, 2017.

During the CAP period, the facility and agency were able to complete all CAP items. Thus, it was determined that the Facility "Exceed Standard" on one PREA Standard (115.351); "Meets Standard" on 37 PREA Standards, "Did Not Meet Standard" on zero (0) PREA Standards, while three PREA Standards (115.318; 115.332; and 115.335) were deemed "Not Applicable."

The following is a Standard-by-Standard summary of this Auditor's findings, including the Corrective Actions items, if any, in this PREA Audit.

Number of standards exceeded: 01

Number of standards met: 37

Number of standards not met: 00

Number of standards not applicable: 03

Standard 115.311 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.311: This standard has three components (a) An agency shall have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment and outlining the agency’s approach to preventing, detecting, and responding to such conduct; (b) An agency shall employ or designate an upper-level, agency-wide PREA coordinator with sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities; and (c) Where an agency operates more than one facility, each facility shall designate a PREA compliance manager with sufficient time and authority to coordinate the facility’s efforts to comply with the PREA standards.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the following: 1) MDOC Policy number 1.1.17; 2) the Pre-Audit Questionnaire; 3) MDOC's Organizational Chart; 4) The Facility’s Organizational Chart; 5) Facility policy number 10-5 and 6) Interviews with staff.

OBSERVATIONS: The Agency’s 1.1.17 Policy is determined to meet standard. Further, the Agency employees an upper-level, agency-wide, PREA coordinator with sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities; and the Facility designated a PREA compliance manager with sufficient time and authority to coordinate the facility’s efforts to comply with the PREA standards.

DETERMINATION: Based on the observations noted above it was determined that the Agency *does* meet this Standard.

Standard 115.312 Contracting with other entities for the confinement of residents

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.312: This standard has two components: (a) A public agency that contracts for the confinement of its inmates with private agencies or other entities, including other government agencies, shall include in any new contract or contract renewal the entity’s obligation to adopt and comply with the PREA standards; (b) Any new contract or contract renewal shall provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the following: 1) the Pre-Audit Questionnaire; 2) Samples of signed contracts; and 3) Interview(s) with the Agency and Facility staff responsible for contract monitoring.

OBSERVATIONS: The Agency began contracting for confinement services of residents after the last juvenile PREA Audit. In a review of the contract, it was noted that the contract included the entity's obligation to adopt and comply with the PREA standards and that the contract did have language that ensured that contract monitoring was provided. Agency staff interviews confirmed that contactor monitoring did take place, including at least quarterly site visits to the facility.

DETERMINATION: Based on the observations noted above it was determined that the Agency *does* meet this standard.

Standard 115.313 Supervision and monitoring

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.313: This standard has four components: (a) a staffing plan has been created; (b) deviations from the staffing plan are documented; (c) the staffing plan is reviewed annually; and (d) for secure facilities, where unannounced rounds occur, staff are prohibited from alerting other staff that such rounds are occurring.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the following: 1) MDOC Policy number 1.1.17; 2) the Pre-Audit Questionnaire; 3) Facility's Staffing Plan; 4) Review of Unannounced Rounds Log; and 5) Interviews with staff.

OBSERVATIONS: The Facility's Staffing Plan, as presented, is consistent with the intent of the PREA Standard

DETERMINATION: It was determined that the Facility *does* meet this Standard.

Standard 115.315 Limits to cross-gender viewing and searches

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.315: This standard has six components: (a) The facility shall not conduct cross-gender strip searches or cross-gender visual body cavity searches (meaning a search of the anal or genital opening) except in exigent circumstances or when performed by medical practitioners; (b) The agency shall not conduct cross-gender pat-down searches except in exigent circumstances; (c) The facility shall document all cross-gender strip searches and cross-gender visual body cavity

searches, and shall document all cross-gender pat-down searches of female inmates; (d) The facility shall implement policies and procedures that enable inmates 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. Such policies and procedures shall require staff of the opposite gender to announce their presence when entering an inmate housing unit; (e) The facility shall not search or physically examine a transgender or intersex inmate for the sole purpose of determining the inmate's genital status. If the inmate's genital status is unknown, it may be determined during conversations with the inmate, 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; and (f) The agency shall train security staff in how to conduct cross-gender pat-down searches, and searches of transgender and intersex inmates, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the following: 1) MDOC Policy number 1.1.17; 2) the Pre-Audit Questionnaire; 3) Interviews with nine security staff; 3) Review of staff training files; and 4) Interviews with residents (specifically, all seven residents enrolled at the Facility during the audit).

OBSERVATIONS: Based on observation, document review, and interviews, the Facility was compliant with all PREA components related to this Standard.

DETERMINATION: It was determined that the Facility *does* meet this Standard.

Standard 115.316 Residents with disabilities and residents who are limited English proficient

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.316: This standard has three components: (a) The agency shall take appropriate steps to ensure that inmates with disabilities (including, for example, inmates who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities), have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment; (b) The agency shall 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 inmates who are limited English proficient, including steps to provide interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary; and (c) The agency shall not rely on inmate interpreters, inmate readers, or other types of inmate assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the inmate's safety, the performance of first-response duties under §115.64, or the investigation of the inmate's allegations.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the following: 1) the MDOC Policy number 1.1.17; 2) the Pre-Audit Questionnaire; 3) Various forms; 4) Interviews with nine security staff; 5) the contract for Interpreter Services through an outside provider; and 6) Interviews with residents.

OBSERVATIONS: MDOC Policy 1.1.17 complies with this standard. Further, the Agency maintains a contract for Interpreter Services with an outside service that is utilized as needed. In interviews with security staff all nine reported that they would either access the translation services or secure approval from supervisor to do so. Further, all of the staff reported that they would NOT allow residents to interpret for other residents unless it was an exigent circumstance.

DETERMINATION: It was determined that the Facility does meet this Standard.

Standard 115.317 Hiring and promotion decisions

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.317: This standard has eight components: (a) The agency shall not hire or promote anyone who may have contact with inmates, and shall not enlist the services of any contractor who may have contact with inmates, who— [(1) Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); (2) Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or (3) Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section]; (b) The agency shall consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with inmates; (c) Before hiring new employees who may have contact with inmates, the agency shall: [(1) Perform a criminal background records check; and (2) Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse]; (d) The agency shall also perform a criminal background records check before enlisting the services of any contractor who may have contact with inmates; (e) The agency shall either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with inmates or have in place a system for otherwise capturing such information for current employees; (f) The agency shall ask all applicants and employees who may have contact with inmates directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The agency shall also impose upon employees a continuing affirmative duty to disclose any such misconduct; (g) Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination; and (h) Unless prohibited by law, the agency 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.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility relied on the following: 1) Pre-Audit Questionnaire; 2) MDOC Policy 1.1.17; 3) Review of 13 staff files; 4) Review of contractor and volunteer files; and 5) Onsite audit interviews with staff (specifically, MDOC Human Resource staff).

OBSERVATIONS: In a review of 13 staff files and interviews with HR staff, found that background checks were performed on all new hires and for staff employed for more than four years. Child abuse registries were checked prior to staff being employed. Further, former institutional employers were contacted. The agency does ask all staff who may have contact with residents about if they have “been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section” and these questions are being asked during the promotion process and during annual performance evaluation. Further, the Agency is considering any incidents of sexual harassment in determining whether to hire an employee but only asks about sexual harassment instances related to inmates and residents during promotions. However, this is determined to meet the intent of the standard. This auditor could not find any policy or procedure that imposes upon employees a continuing affirmative duty to disclose any such misconduct (specifically civil). Interviews with HR Staff noted

that the Agency would provide, to the extent allowable by law, information related to a substantiated allegation of sexual abuse or sexual harassment to other law enforcement agencies.

DETERMINATION: It was determined that the agency *does not* meet this Standard.

CORRECTIVE ACTION PLAN (CAP): The facility entered the CAP period on August 18, 2017. The agency/facility shall: (1) Revise policy to ensure that staff have a continuing affirmative duty to disclose any such misconduct described in this Standard and (2) Submit to this Auditor evidence that the revised policy/procedure is in effect.

FINAL DETERMINATION: During the CAP period, the agency and facility were able to revise policy to ensure that staff have a continuing affirmative duty to disclose any such misconduct described in this Standard and agency staff submit to this Auditor evidence that the revised policy/procedure is in effect. Thus, on August 29, 2017, the agency and facility were deemed to meet this standard.

Standard 115.318 Upgrades to facilities and technologies

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.318: This standard has two components: (a) When designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, the agency shall consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse; and (b) When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, the agency shall consider how such technology may enhance the agency's ability to protect residents from sexual abuse.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the Pre-Audit Questionnaire, a facility tour, and interviews with staff (specifically, the Facility Superintendent and the Facility's staff and residents).

OBSERVATIONS: There have been no substantial expansion or modifications to any Facilities since August 2012.

DETERMINATION: Based on the Agency and Facility policies and procedures, Pre-Audit Questionnaire, and the Onsite Audit (including the Facility tour and the staff and resident interviews), it was determined that this Standard is *not applicable* to the Facility.

Standard 115.321 Evidence protocol and forensic medical examinations

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.321: This standard has eight components: (a) To the extent the agency is responsible for investigating allegations of sexual abuse, the agency shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions; (b) The protocol shall be developmentally appropriate for youth and, as appropriate, shall be 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; (c) The agency shall offer all residents who experience sexual abuse access to forensic medical examinations whether on-site or at an outside facility, without financial cost, where evidentiary or medically appropriate. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The agency shall document its efforts to provide SAFEs or SANEs; (d) The agency shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the agency shall make available to provide these services a qualified staff member from a community-based organization or a qualified agency staff member. Agencies shall document efforts to secure services from rape crisis centers. For the purpose of this standard, a rape crisis center refers to an entity that provides intervention and related assistance, such as the services specified in 42 U.S.C. 14043g(b)(2)(C), to victims of sexual assault of all ages. The agency may utilize a rape crisis center that is part of a governmental unit as long as the center is not part of the criminal justice system (such as a law enforcement agency) and offers a comparable level of confidentiality as a nongovernmental entity that provides similar victim services; (e) As requested by the victim, the victim advocate, qualified agency staff member, or qualified community-based organization staff member shall accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals; (f) To the extent the agency itself is not responsible for investigating allegations of sexual abuse, the agency shall request that the investigating agency follow the requirements of paragraphs (a) through (e) of this section; (g) The requirements of paragraphs (a) through (f) of this section shall also apply to: [(1) Any State entity outside of the agency that is responsible for investigating allegations of sexual abuse in juvenile facilities; and (2) Any Department of Justice component that is responsible for investigating allegations of sexual abuse in juvenile facilities.] (h) For the purposes of this standard, a qualified agency staff member or a qualified community-based staff member shall be an individual who has been screened for appropriateness to serve in this role and has received education concerning sexual assault and forensic examination issues in general.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) MDOC Policy 1.1.17, (3) Interviews with the PREA Compliance Manager (PCM), and (4) interviews with staff (specifically, the Facility Superintendent, Agency investigator, and Facility investigator).

OBSERVATIONS: The Facility does have investigators who conduct both criminal and administrative investigations. There is documentation that local law enforcement and/or local hospitals whose staff may perform a forensic exam were asked to utilize 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.

DETERMINATION: It was determined that the Facility *does* meet this Standard.

Standard 115.322 Policies to ensure referrals of allegations for investigations

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.322: This standard has five components: (a) The agency shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment; (b) The agency shall have in place a policy 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. The agency shall publish such policy on its website or, if it does not have one, make the policy available through other means. The agency shall document all such referrals; (c) If a separate entity is responsible for conducting criminal investigations, such publication shall describe the responsibilities of both the agency and the investigating entity; (d) Any State entity responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in juvenile facilities shall have in place a policy governing the conduct of such investigations; (e) Any Department of Justice component responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in juvenile facilities shall have in place a policy governing the conduct of such investigations.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) MDOC Policy 1.1.17, (3) MDOC Policy 3.3.3., (4) interviews with staff (specifically, the Facility Superintendent, the Agency investigator, and the Facility investigator), (5) Copies of completed investigations, and (6) the Facility website.

OBSERVATIONS: The Facility does have a policy that all allegations of sexual abuse and sexual harassment would be investigated. This policy (with effective date 6/28/2016) adequately addresses the components related to this PREA standard. In addition, interviews of staff and residents confirmed that any allegations of sexual abuse or sexual harassment would be investigated.

DETERMINATION: It was determined that the Facility does meet this Standard.

Standard 115.331 Employee training

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.331: This standard has four components: (a) The agency shall train all employees who may have contact with residents on 11 required topics; (b) Such training shall be tailored to the unique needs and attributes of residents of juvenile facilities and to the gender of the residents at the employee's facility. The employee shall receive additional training if the employee is reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa; (c) All current employees who have not received such training shall be trained within one year of the effective date of the PREA standards, and the agency shall 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. In years in

which an employee does not receive refresher training, the agency shall provide refresher information on current sexual abuse and sexual harassment policies; and (d) The agency shall document, through employee signature or electronic verification, that employees understand the training they have received.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) MDOC Policy 1.1.17, (3) interviews with staff, (4) Training forms, and (5) Training curricula.

OBSERVATIONS: All nine of the security staff interviewed noted that they did receive all of the required PREA training. All staff interviews noted they felt they receive training that was specific to the “unique needs and attributes and gender of the residents at the Facility.” In a review of staff files it was apparent that staff received the required PREA training prior to having contact with residents.

DETERMINATION: It was determined that the Facility *does* meet this Standard.

Standard 115.332 Volunteer and contractor training

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.332: This standard has three components: (a) The agency shall ensure 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; (b) The level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents, but all volunteers and contractors who have contact with residents shall be notified of the agency’s zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents; and (c) The agency shall maintain documentation confirming that volunteers and contractors understand the training they have received.

EVIDENCE OF COMPLIANCE: The Facility’s Pre-Audit Questionnaire, training forms, training curricula, and interviews with staff.

OBSERVATIONS: The facility did not have any volunteers or contractors.

DETERMINATION: It was determined that this standard is not applicable.

Standard 115.333 Resident education

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.333: This standard has six components: (a) During the intake process, residents shall receive information explaining, in an age appropriate fashion, the agency’s zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment; (b) Within 10 days of intake, the agency shall provide comprehensive age-appropriate education to residents either in person or through video regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents; (c) Current residents who have not received such education shall be educated within one year of the effective date of the PREA standards, and shall receive education upon transfer to a different facility to the extent that the policies and procedures of the resident’s new facility differ from those of the previous facility; (d) The agency shall provide resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to residents who have limited reading skills; (e) The agency shall maintain documentation of resident participation in these education sessions; and (f) In addition to providing such education, the agency shall ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) MDOC Policy 1.1.17, (3) interviews with residents, (4) Training forms, (5) Training curricula, and (6) A review of 11 resident files (both current and former residents).

OBSERVATIONS: In a review of seven current residents’ files (100.0% of current resident population) and four (4) former resident files it was found that all residents, or 100.0%, had documentation noting when the residents PREA information was provided and all 11, or 100.0%, did have documentation supporting the fact that they received PREA Education within 10 days of Intake.

DETERMINATION: It was determined that the Facility *does* meet this Standard.

Standard 115.334 Specialized training: Investigations

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.334: This standard has four components: (a) In addition to the general training provided to all employees pursuant to § 115.331, the agency shall ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings; (b) Specialized training shall include techniques for interviewing juvenile 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; (c) The agency shall maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations; and (d) Any State entity or Department of Justice component that investigates sexual abuse in juvenile confinement settings shall provide such training to its agents and investigators who conduct such investigations.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) MDOC Policy 1.1.17, (3) interviews with Agency and Facility investigators, and (4) Training forms.

OBSERVATIONS: Agency provided evidence that all investigators had completed the required PREA training. The Facility did provide evidence that all the designated Facility Investigator's completed this training. Interviews with investigators noted that each had received the required training.

DETERMINATION: It was determined that the Facility does meet this Standard.

Standard 115.335 Specialized training: Medical and mental health care

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.335: This standard has four components: (a) The agency shall ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in [(1) How to detect and assess signs of sexual abuse and sexual harassment; (2) How to preserve physical evidence of sexual abuse; (3) How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment; and (4) How and to whom to report allegations or suspicions of sexual abuse and sexual harassment]; (b) If medical staff employed by the agency conduct forensic examinations, such medical staff shall receive the appropriate training to conduct such examinations; (c) 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; and (d) Medical and mental health care practitioners shall also receive the training mandated for employees under §115.331 or for contractors and volunteers under §115.332, depending upon the practitioner's status at the agency.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) MDOC Policy 1.1.17, (3) interviews with staff, and (4) Training forms.

OBSERVATIONS: Interviews with the administrative staff confirmed that there are no full-time nor part-time medical and mental health care practitioners who work regularly in the Facility.

DETERMINATION: Based on the Agency and Facility policies and procedures, Pre-Audit Questionnaire, and the Onsite Audit (including the Facility tour and the staff and resident interviews), it was determined that this Standard is *not applicable* to the Facility.

Standard 115.341 Screening for risk of victimization and abusiveness

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.341: This standard has five components: (a) Within 72 hours of the resident's arrival at the facility and periodically throughout a resident's confinement, the agency shall obtain and use information about each resident's personal history and behavior to reduce the risk of sexual abuse by or upon a resident; (b) Such assessments shall be conducted using an objective screening instrument; (c) At a minimum, the agency shall attempt to ascertain 11 pieces of required information (see standard); (d) This information shall be ascertained through conversations with the resident during the intake process and medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files; and (e) The agency shall implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) MDOC Policy 1.1.17, (3) interviews with staff (specifically, counseling staff responsible for assessing risk), (4) the *Screening for Sexually Assaultive Behavior, Sexually Abusive Behavior, and Risk for Sexual Victimization* forms; and (5) A review of 11 resident files (both current and former residents).

OBSERVATIONS: The Facility uses a risk assessment tool that utilizes each resident's intake responses to a variety of questions, including past victimizations and abusiveness. This information is used to help determine a youth's risk of sexual aggression and sexual vulnerability. The staff uses a screening tool, a personal interview, and any other available relevant records to assess each youth's risk for sexual aggressive behavior and vulnerability to sexual victimization. Staff are aware that they are to consider gender nonconforming or manner or identification. In a review of 11 resident files, all 11, or 100.0%, did have documentation showing that a Screening was performed within the required 72-hour timeframe.

DETERMINATION: It was determined that the Facility does meet this Standard.

Standard 115.342 Use of screening information

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.342: This standard has nine components: (a) The agency shall use all information obtained pursuant to § 115.341 and subsequently to make housing, bed, program, education, and work assignments for residents with the goal of keeping all residents safe and free from sexual abuse; (b) Residents may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged. During any period of isolation, agencies shall not deny residents daily large-muscle exercise and any legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible; (c) Lesbian, gay, bisexual, transgender, or intersex residents shall not be placed in

particular housing, bed, or other assignments solely on the basis of such identification or status, nor shall agencies consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive; (d) In deciding whether to assign a transgender or intersex resident to a facility for male or female residents, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether the placement would present management or security problems; (e) Placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year to review any threats to safety experienced by the resident; (f) A transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration; (g) Transgender and intersex residents shall be given the opportunity to shower separately from other residents; (h) If a resident is isolated pursuant to paragraph (b) of this section, the facility shall clearly document: [(1) The basis for the facility's concern for the resident's safety; and (2) The reason why no alternative means of separation can be arranged]; and (i) Every 30 days, the facility shall afford each resident described in paragraph (h) of this section a review to determine whether there is a continuing need for separation from the general population.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) MDOC Policy 1.1.17, (3) interviews with residents, and (4) Interviews with staff.

OBSERVATIONS: All nine staff interviewed supported the contention that the Facility "never" places a resident in isolation for their own protection against sexual victimization. In a review of the policy (1.1.17) it was stated that the Facility could place a resident in isolation for their own protection. Though the facility staff did not know if a transgender or intersex resident had been in the facility, each staff interviewed recognized that there were no areas of the facility designated as housing areas for these residents.

DETERMINATION: It was determined that the Facility *does* meet this Standard.

Standard 115.351 Resident reporting

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.351: This standard has five components: (a) The agency shall provide multiple internal ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents; (b) The agency shall also provide 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 and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request. Residents detained solely for civil immigration purposes shall be provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security; (c) Staff shall accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports; (d) The facility shall provide residents with access to tools necessary to make a written report; and (e) The agency shall provide a method for staff to privately report sexual abuse and sexual harassment of residents.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) MDOC Policy 1.1.17, (3) interviews with residents, (4) Interviews with staff, (5)

Access to the phone system to make a call to an outside agency; and (6) Review of allegations and investigations of those allegations.

OBSERVATIONS: All staff and residents were able to identify multiple internal ways for a youth to report privately to Facility officials about sexual abuse, sexual harassment, retaliation, and staff neglect or violation of responsibilities that may have contributed to any such incidents. All of the interviewed residents noted that they would tell a staff member, use the posted phone numbers and/or report to their parent or guardians. Posters with the hotline numbers were observed posted in each residential unit at Facility. A test of the PREA Hotline noted that the call was answered immediately and by a “live” person. Further, it was found that a “live” person answered the phone 24/7 and that the PREA Coordinator is immediately notified. Further, it was determined that the resident calling this number could remain anonymous if they so choose. As for residents detained solely for civil immigration purposes, this practice is not allowed per statement from the Facility and interviews with staff. All staff, who were interviewed, acknowledged that they must report all verbal reports, anonymous reports, written reports, and reports from third parties regarding allegations of sexual abuse and sexual harassment.”

DETERMINATION: It was determined that the Facility *exceeds* the requirements for this Standard.

Standard 115.352 Exhaustion of administrative remedies

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.352: This standard has seven components: (a) An agency shall be exempt from this standard if it does not have administrative procedures to address resident grievances regarding sexual abuse; (b)(1) The agency shall not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse; (2) The agency may apply otherwise-applicable time limits on any portion of a grievance that does not allege an incident of sexual abuse; (b)(3) The agency shall not require a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse; (b)(4) Nothing in this section shall restrict the agency’s ability to defend against a lawsuit filed by a resident on the ground that the applicable statute of limitations has expired; (c) The agency shall ensure that [(1) A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint, and (2) Such grievance is not referred to a staff member who is the subject of the complaint]; (d)(1) The agency shall issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance; (d)(2) Computation of the 90-day time period shall not include time consumed by residents in preparing any administrative appeal; (d)(3) The agency may claim an extension of time to respond, of up to 70 days, if the normal time period for response is insufficient to make an appropriate decision. The agency shall notify the resident in writing of any such extension and provide a date by which a decision will be made; (d)(4) At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, the resident may consider the absence of a response to be a denial at that level; (e)(1) Third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, shall be permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and shall also be permitted to file such requests on behalf of residents; (e)(2) If a third party, other than a parent or legal guardian, 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; (e)(3) If the resident declines to have the request processed on his or her behalf, the agency shall document the resident’s decision; (e)(4) A parent or legal guardian of a juvenile shall be allowed to file a grievance

regarding allegations of sexual abuse, including appeals, on behalf of such juvenile. Such a grievance shall not be conditioned upon the juvenile agreeing to have the request filed on his or her behalf; (f)(1) The agency shall establish procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse; (f)(2) After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, the agency shall 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, shall provide an initial response within 48 hours, and shall issue a final agency decision within 5 calendar days. The initial response and final agency decision shall document the agency's determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance; and (g) The agency may discipline a resident for filing a grievance related to alleged sexual abuse only where the agency demonstrates that the resident filed the grievance in bad faith.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) MDOC Policy 3.3.3., and (3) Interviews with staff.

OBSERVATIONS: The agency's Offender Grievance Program (with effective date 6/28/2016) meets the components related to this standard. Further, staff interviews acknowledged that the Offender Grievance Program would be followed.

DETERMINATION: It was determined that the Facility does meet this Standard.

Standard 115.353 Resident access to outside confidential support services

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.353: This standard has four components: (a) The facility shall provide residents with access to outside victim advocates for emotional support services related to sexual abuse, by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations, and, for persons detained solely for civil immigration purposes, immigrant services agencies. The facility shall enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible; (b) The facility shall inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws; (c) The agency shall 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. The agency shall maintain copies of agreements or documentation showing attempts to enter into such agreements; and (d) The facility shall also provide residents with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) MDOC Policy 1.1.17, (3) interviews with residents, and (4) Interviews with staff.

OBSERVATIONS: The Facility provided contact phone numbers and addresses to the Montana Department of Corrections and with Voices of Hope in Great Falls. All interviews (staff and residents) confirmed and acknowledged that residents are provided with reasonable access to parents or legal guardians and that all residents are provided reasonable and confidential

access to their attorneys or other legal representative.

DETERMINATION: It was determined that the Facility *does* meet this Standard.

Standard 115.354 Third-party reporting

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.354: This standard has one component: (a) The agency shall establish a method to receive third-party reports of sexual abuse and sexual harassment and shall distribute publicly information on how to report sexual abuse and sexual harassment on behalf of a resident.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) MDOC Policy 1.1.17, (3) interviews with residents, (4) Interviews with staff, and (5) Interview with the State of Montana's PREA Administrator were used to assess compliance with this Standard.

OBSERVATIONS: This Facility has multiple means of receiving third-party reports, including phone calls to the Facility and via the dial 9 number. Further, the Facility's website has a process for families to report sexual abuse and sexual harassment.

DETERMINATION: It was determined that the Facility *does* meet this Standard.

Standard 115.361 Staff and agency reporting duties

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.361: This standard has six components: (a) The agency shall require all staff to report immediately and according to agency 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; 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; (b) The agency shall also require all staff to comply with any applicable mandatory child abuse reporting laws; (c) Apart from reporting to designated supervisors or officials and designated State or local services agencies, staff shall be prohibited 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; (d)(1) Medical and mental health practitioners shall be required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section, as well as to the designated State or local services agency where required by mandatory reporting laws; (d)(2) Such practitioners shall be required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality; (e)(1) Upon receiving any allegation of sexual abuse, the facility head or his or her designee shall promptly report the allegation to the appropriate agency office and to the alleged victim's parents or legal guardians, unless the facility has official documentation showing the parents or legal guardians should not be notified; (e)(2) If the alleged victim is under the guardianship of the child welfare system, the report shall be made to the alleged victim's caseworker instead of the parents or legal guardians; (e)(3) If a juvenile court retains jurisdiction over the alleged victim, the facility head or designee shall also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation; and (f) The facility shall report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) MDOC Policy 1.1.17, (3) MDOC 3.3.3, and (4) Interviews with staff.

OBSERVATIONS: MDOC Policy 1.1.17 and YTC Policy 10-5 plus staff interviews, supported the contention that the Facility is following this PREA Standard. All staff noted they understood that they were "mandatory reporters" and had to report any suspicion of child abuse.

DETERMINATION: It was determined that the Facility *does* meet this Standard.

Standard 115.362 Agency protection duties

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.362: This standard has one component: (a) When an agency learns that a resident is subject to a substantial risk of imminent sexual abuse, it shall take immediate action to protect the resident.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) MDOC Policy 1.1.17, (3) interviews with residents, and (4) Interviews with staff.

OBSERVATIONS: MDOC Policy 1.1.17 specifically addresses this requirement. During interviews all nine staff noted that they would act immediately to protect a resident who was subject to a substantial risk of imminent sexual abuse. Further, all interviewed residents noted that they would "tell staff" if they felt they were at a substantial risk of imminent sexual abuse.

DETERMINATION: It was determined that the Facility, in all material ways, meets this Standard.

Standard 115.363 Reporting to other confinement facilities

- Exceeds Standard (substantially exceeds requirement of standard)

- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.363: This standard has four components: (a) Upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility that received the allegation shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred and shall also notify the appropriate investigative agency; (b) Such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation; (c) The agency shall document that it has provided such notification; and (d) The facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) MDOC Policy 1.1.17, (3) Interviews with staff, and (4) Interviews with the Facility Head.

OBSERVATIONS: MDOC 1.1.17, page 5, mentions this requirement and this policy notes that “Allegations that an offender was sexually abused while at another facility or program must be reported by the administrator to the administrator of the facility or program where the abuse occurred as soon as possible but no later than 72 hours after the initial report. For allegations involving a resident of a juvenile facility the administrator will also notify the appropriate investigative agency.” Interviews with the Facility Head noted he understood this requirement.

DETERMINATION: It was determined that the Facility *does* meet this Standard.

Standard 115.364 Staff first responder duties

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.364: This standard has two components: (a) Upon learning of an allegation that a resident was sexually abused, the first 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; and (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]; and (b) If the first staff responder is not a security staff member, the responder shall

be required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) MDOC Policy 1.1.17, (3) YTC 10-5, (4) Interviews with staff, and (5) Interviews with the Facility Head.

OBSERVATIONS: All staff reported that they understood their role as first responder and all nine staff who were interviewed were able to describe the procedures that a first responder is to use. YTC Policy 10-5 adheres to this Standard.

DETERMINATION: It was determined that the Facility *does* meet this Standard.

Standard 115.365 Coordinated response

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.365: This standard has one component: (a) The facility shall develop 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.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) MDOC Policy 1.1.17, (3) YTC 10-5, (4) Interviews with staff, and (5) Interviews with the Facility Head.

OBSERVATIONS: The Facility could provide a written *Coordinated Response Plan* and all staff interviewed noted that they would follow the CRP, if a sexual abuse allegation was alleged.

DETERMINATION: It was determined that the Facility *does* meet this Standard.

Standard 115.366 Preservation of ability to protect residents from contact with abusers

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.366: This standard has two components: (a) Neither the agency nor any other governmental entity responsible for collective bargaining on the agency's behalf shall enter into or renew any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted, and (b) Nothing in this standard shall restrict the entering into or renewal of agreements that govern: [(1) The conduct of the disciplinary process, as long as such agreements are not inconsistent with the provisions of §§ 115.372 and 115.376; or (2) Whether a no-contact assignment that is imposed pending the outcome of an investigation shall be expunged from or retained in the staff member's personnel file following a determination that the allegation of sexual abuse is not substantiated.]

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire and (2) Interview with the Agency Head.

OBSERVATIONS: An interview with the MDOC Agency Head designee noted that the agency/state *does* have a collective bargaining agreement that was completed since August of 2016, and being renegotiated this month. However, nothing in the agreement limits the agency's ability to remove alleged staff sexual abusers from contact with residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted.

DETERMINATION: It was determined that the Facility, in all material ways, meets this Standard.

Standard 115.367 Agency protection against retaliation

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.367: This standard has six components: (a) The agency shall establish 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 and shall designate which staff members or departments are charged with monitoring retaliation; (b) The agency shall 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; (c) For at least 90 days following a report of sexual abuse, the agency shall monitor the conduct or treatment of residents or staff who reported the sexual abuse and 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, and shall act promptly to remedy any such retaliation. Items the agency should monitor include any resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. The agency shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need; (d) In the case of residents, such monitoring shall also include periodic status checks; (e) If any other individual who cooperates with an investigation expresses a fear of retaliation, the agency shall take appropriate measures to protect that individual against retaliation; and (f) An agency's obligation to monitor shall terminate if the agency determines that the allegation is unfounded.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) MDOC Policy 1.1.17, (3) YTC Policy 10-5; (4) MDOC 3.3.3, (5) Interviews with staff, (6) Interviews with residents; (7) Interviews with specialized staff; and (8) Reports of sexual abuse/sexual harassment allegations.

OBSERVATIONS: MDOC Policy 1.1.17 addresses subsection (a) of this component. Interviews with staff responsible for retaliation monitoring noted that all staff were aware that retaliation monitoring should last at least 90-days.

DETERMINATION: It was determined that the Facility *does* meet this Standard.

Standard 115.368 Post-allegation protective custody

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.368: This standard has one component: (a) Any use of segregated housing to protect a resident who is alleged to have suffered sexual abuse shall be subject to the requirements of § 115.342.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) MDOC Policy 1.1.17, (3) YTC Policy 10-5, (4) Interviews with staff, and (5) Interviews with specialize staff.

OBSERVATIONS: All nine staff interviewed supported the contention that the Facility “never” places a resident in isolation for their own protection against sexual victimization. In a review of the policy (1.1.17) it was stated that the Facility could place a resident in isolation for their own protection. Further, the policy does require that during any period of isolation, agencies shall not deny residents daily large-muscle exercise and any legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible.

DETERMINATION: It was determined that the Facility *does* meet this Standard. DETERMINATION: It was determined that the Facility *does* meet this Standard.

Standard 115.371 Criminal and administrative agency investigations

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.371: This standard has 13 components: (a) When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, it shall do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports; (b) Where sexual abuse is alleged, the agency shall use investigators who have received special training in sexual abuse investigations involving juvenile victims pursuant to § 115.334; (c) Investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator; (d) The agency shall not terminate an investigation solely because the source of the allegation recants the allegation; (e) When the quality of evidence appears to support criminal prosecution, the agency shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution; (f) The credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person's status as resident or staff. No agency shall require a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation; (g) Administrative investigations: [(1) Shall include an effort to determine whether staff actions or failures to act contributed to the abuse; and (2) Shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings]; (h) Criminal investigations shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible; (i) Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution; (j) The agency shall retain all written reports referenced in paragraphs (g) and (h) of this section for as long as the alleged abuser is incarcerated or employed by the agency, plus five years, unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention; (k) The departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation; (l) Any State entity or Department of Justice component that conducts such investigations shall do so pursuant to the above requirements; and (m) When outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) MDOC Policy 1.1.17, (3) YTC Policy 10-5, (4) MDOC Policy 3.3.3, (5) Interviews with staff, and (6) Interviews with Agency and Facility Investigators.

OBSERVATIONS: It was determined that the Agency has trained investigative staff and that they would conduct investigations into sexual abuse and sexual harassment. Interviews with investigators supported the contention that the Agency and Facility were meeting this standard. Results of reviewed investigations also supported the contention the Facility was meeting all components of this Standard.

DETERMINATION: It was determined that the Facility *does* meet this Standard.

Standard 115.372 Evidentiary standard for administrative investigations

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.372: This standard has one component: (a) The agency shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) MDOC Policy 1.1.17, (3) YTC Policy 10-5, and (4) Interviews with investigators.

OBSERVATIONS: Staff noted that they would only use a Standard of “preponderance of evidence” in determining whether allegations of sexual abuse or sexual harassment are substantiated. Further, Facility policy notes that the Facility shall use the Standard of preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated

DETERMINATION: It was determined that the Facility, in all material ways, meets this Standard.

Standard 115.373 Reporting to residents

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.373: This standard has six components: (a) Following an investigation into a resident’s allegation of sexual abuse suffered in an agency facility, the agency shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded; (b) If the agency did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the resident; (c) Following a resident’s allegation that a staff member has committed sexual abuse against the resident, the agency shall subsequently inform the resident (unless the agency has determined that the allegation is unfounded) whenever [(1) The staff member is no longer posted within the resident’s unit; (2) The staff member is no longer employed at the facility; (3) The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or (4) The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility]; (d) Following a resident’s allegation that he or she has been sexually abused by another resident, the agency shall subsequently inform the alleged victim whenever: [(1) The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or (2) The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility]; (e) All such notifications or attempted notifications shall be documented; and (f) An agency’s obligation to report under this standard shall terminate if the resident is released from the agency’s custody.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) MDOC Policy 1.1.17, (3) Interviews with PCM, (4) Interviews with investigators, and (5) Review of completed sexual abuse investigations.

OBSERVATIONS: Policy 1.1.17 addresses this Standard and in interviews with staff confirmed they would document these attempts.

DETERMINATION: It was determined that the Facility *does* meet this Standard.

Standard 115.376 Disciplinary sanctions for staff

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.376: This standard has four components: (a) Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies; (b) Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse; (c) Disciplinary sanctions for violations of agency 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; (d) 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, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) MDOC Policy 1.1.17, (3) Interviews with PCM, (4) Interviews with investigators, (5) Interviews with HR staff; and (6) Review of completed sexual abuse investigations.

OBSERVATIONS: MDOC Policy 1.1.17 (specifically subsection K) addresses this Standard. Interviews supported the contention that staff would be disciplined for violating the sexual abuse and/or sexual harassment policies. Further, MDOC 1.1.17 specifically states that termination is the presumptive disciplinary sanction.

DETERMINATION: It was determined that the Facility *does* meet this Standard.

Standard 115.377 Corrective action for contractors and volunteers

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.377: This standard has two components: (a) Any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with residents and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies; and (b) The facility shall take appropriate remedial measures, and shall consider whether to prohibit further contact with residents, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) MDOC Policy 1.1.17, (3) Interviews with PCM, (4) Interviews with investigators, (5) Interviews with HR staff; and (6) Review of completed sexual abuse investigations.

OBSERVATIONS: MDOC Policy 1.1.17 notes that “service providers who violate this policy are subject to administrative discipline including termination of employment, criminal sanctions, or both.” Further, the Policy notes that the service providers who violate this policy “shall be prohibited from contact with residents and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies.” Interviews with administrative staff noted that they would prohibit further contact with residents, in the case of any violation of agency sexual abuse or sexual harassment policies by a service provider or volunteer and the staff interviewed noted that HR would make contact with the appropriate licensing bodies.

DETERMINATION: It was determined that the Facility *does* meet this Standard.

Standard 115.378 Disciplinary sanctions for residents

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.378: This standard has seven components: (a) A resident may be 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 or following a criminal finding of guilt for resident-on-resident sexual abuse; (b) Any disciplinary sanctions shall be 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. In the event a disciplinary sanction results in the isolation of a resident, agencies shall not deny the resident daily large-muscle exercise or access to any legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible; (c) The disciplinary process shall consider whether a resident’s mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed; (d) If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility shall consider whether to offer the offending resident participation in such interventions. The agency may require participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, but not as a condition to access to general programming or education; (e) The agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact; (f) For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation; and (g) An agency may, in its discretion, prohibit all sexual activity between residents and may discipline residents for such activity. An agency may not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) MDOC Policy 1.1.17, (3) YTC Policy 10-5, (4) Interview with the PCM, and (5) Interviews with Facility Head.

OBSERVATIONS: It was noted that MDOC Policy 1.1.17 that youth will be disciplined per the appropriate disciplinary code or PREA Audit Report

code of conduct. Based on the pre-onsite visit conference calls with the Facility Head and via the Pre-Audit Questionnaire, and via interviews during the onsite, the Facility would not use isolation as the sole sanction for resident-on-resident sexual abuse. Interviews with staff noted that they consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. Finally, interviews supported the contention that a resident would not be disciplined if they make a report of sexual abuse in 'good faith'.

DETERMINATION: It was determined that the Facility *does* meet this Standard.

Standard 115.381 Medical and mental health screenings; history of sexual abuse

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.381: This standard has four components: (a) If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, staff shall ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening; (b) If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, staff shall ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening; (c) Any information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law; and (d) Medical and mental health practitioners shall obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) MDOC Policy 1.1.17, (3) MDOC Policy 01-04-104, (4) Interview with the PCM, and (5) Interviews with Facility Head.

OBSERVATIONS: Staff interviews acknowledge that staff are aware that medical or mental health practitioner must be offered to a youth within 14 days of staff learning that the youth has experienced prior sexual victimization or has perpetrated sexual abuse. Further, in a review of resident files, of residents who reported prior sexual victimization or sexual abuse perpetration, found that one had documentation that they were offered a medical or mental health follow-up.

DETERMINATION: It was determined that the Facility does meet this Standard.

Standard 115.382 Access to emergency medical and mental health services

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.382: This standard has four components: (a) Resident victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment; (b) If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, staff first responders shall take preliminary steps to protect the victim pursuant to § 115.362 and shall immediately notify the appropriate medical and mental health practitioners; (c) Resident victims of sexual abuse while incarcerated shall be 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; and (d) Treatment services shall be 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.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) MDOC Policy 1.1.17, (3) Interview with the PCM, and (4) Interviews with medical and mental health staff.

OBSERVATIONS: The onsite visit interviews noted that resident victims of sexual abuse are provided with unimpeded access to emergency medical treatment and crisis intervention services. MDOC Policy 1.1.17 on page 4, provides clear directive that supports subsection (a) of this Standard. Nine of nine interviews (100.0%) with staff, who are all trained as first responders, confirmed this component and noted that they are trained to protect the victim and to notify a supervisor who will notify the appropriate medical and mental health practitioners. Further, interviews acknowledged that resident victims of sexual abuse while incarcerated shall be 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

DETERMINATION: It was determined that the Facility *does* meet this Standard.

Standard 115.383 Ongoing medical and mental health care for sexual abuse victims and abusers

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.383: This standard has eight components: (a) The facility shall 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; (b) The evaluation and treatment of such victims shall 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; (c) The facility shall provide such victims with medical and mental health services consistent with the community level of care; (d) Resident victims of sexually abusive vaginal penetration while incarcerated shall be

offered pregnancy tests; (e) If pregnancy results from conduct specified in paragraph (d) of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services; (f) Resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate; (g) Treatment services shall be 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; and (h) The facility shall 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.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) MDOC Policy 1.1.17, (3) Interview with the PCM, and (4) Interviews with medical and mental health staff.

OBSERVATIONS: Interviews confirmed that the Facility is compliant with this Standard and each component. Staff indicated that they would refer residents to the appropriate contractors (i.e., medical and mental health providers) for any resident who reported past sexual abuse and that these services would include medical and mental health evaluation and follow-up, including transition planning.

DETERMINATION: It was determined that the Facility *does* meet this Standard.

Standard 115.386 Sexual abuse incident reviews

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.386: This standard has five components: (a) The facility shall 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; (b) Such review shall ordinarily occur within 30 days of the conclusion of the investigation; (c) The review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners; (d) The review team shall: [(1) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; (2) Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or, gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; (3) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; (4) Assess the adequacy of staffing levels in that area during different shifts; (5) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and (6) Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement and submit such report to the facility head and PREA compliance manager]; (e) The facility shall implement the recommendations for improvement, or shall document its reasons for not doing so.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) MDOC Policy 1.1.17, (3) Interview with the PCM, (4) Interviews with investigators, (5) Interview with Facility Head, and (6) Review of investigations.

OBSERVATIONS: Interviews with staff indicated that the Facility would 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 and that this review would be done within 30-days of the conclusion of the investigation. Policy 1.1.17 further reinforces the Facility's adherence to this PREA Standard.

DETERMINATION: It was determined that the Facility *does* meet this Standard.

Standard 115.387 Data collection

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.387: This standard has six components: (a) The agency shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions; (b) The agency shall aggregate the incident-based sexual abuse data at least annually; (c) The incident-based data collected shall include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence (SSV) conducted by the Department of Justice; (d) The agency shall maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews; (e) The agency also shall obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents; and (f) Upon request, the agency shall provide all such data from the previous calendar year to the Department of Justice no later than June 30.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) MDOC Policy 1.1.17, (3) Survey of Sexual Victimization, (4) Interview with the PCM, (5) Interviews with investigators, (6) Interview with Facility Head, and (7) Interview with the PREA Coordinator.

OBSERVATIONS: The Facility did produce a Standardized instrument so that it can collect accurate uniform data for every allegation of sexual abuse at facilities under its direct control using a Standardized instrument and set of definitions. The instrument provided was the SSV. Data from the MDOC website at <https://cor.mt.gov/Portals/104/Resources/Policy/Forms/2014%20DOC%20PREA%20Report.pdf> notes that aggregated data is presented. An interview with the State of Montana PREA Coordinator, indicated that MDOC maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. Further, the PREA Coordinator noted that the Facility obtains incident-based and aggregated data from every private Facility with which it contracts for the confinement of its residents. The PREA Coordinator also noted that the Facility, upon request, will provide data from the previous calendar year to the Department of Justice no later than June 30.

DETERMINATION: It was determined that the Facility materially meets this Standard.

Standard 115.388 Data review for corrective action

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the

relevant review period)

- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.388: This standard has four components: (a) The agency shall review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including: [(1) Identifying problem areas; (2) Taking corrective action on an ongoing basis; and (3) Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole]; (b) Such report shall include a comparison of the current year's data and corrective actions with those from prior years and shall provide an assessment of the agency's progress in addressing sexual abuse; (c) The agency's report shall be approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means; and (d) The agency may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility, but must indicate the nature of the material redacted.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Interview with the PREA Coordinator, and (3) Annual Report from 2014.

OBSERVATIONS: An annual report is posted at <https://cor.mt.gov/Portals/104/Resources/Policy/Forms/2014%20DOC%20PREA%20Report.pdf>. This report addresses corrective actions taken by Facility type.

DETERMINATION: It was determined that the Facility materially meets this Standard.

Standard 115.389 Data storage, publication, and destruction

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

REQUIREMENTS: 115.389: This standard has four components: (a) The agency shall ensure that data collected pursuant to § 115.387 are securely retained; (b) The agency shall 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; (c) Before making aggregated sexual abuse data publicly available, the agency shall remove all personal identifiers; and (d) The agency shall maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of its initial collection unless Federal, State, or local law requires otherwise.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) MDOC Policy 1.1.17, (3) Interview with the PREA Coordinator, and (4) Annual Report from 2014.

OBSERVATIONS: Interview with the PREA Coordinator, indicated that incident-based and aggregated data were securely retained. Data from the MDOC website at <https://cor.mt.gov/Portals/104/Resources/Policy/Forms/2014%20DOC%20PREA%20Report.pdf> reveals that aggregated data is presented and this is compliant with Agency policy. Further, interviews with the PREA Coordinator indicated that sexual abuse data is collected and maintained for 10 years.

DETERMINATION: It was determined that the Facility *does* meet this Standard.

AUDITOR CERTIFICATION

I certify that:

- The contents of this report are accurate to the best of my knowledge.
- No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Kyle D. Barrington

September 1, 2017

Auditor Signature

Date