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

☐ **Interim** X☐ **Final**

Date of Interim Audit Report: June 29, 2021
If no Interim Audit Report, select N/A
Date of Final Audit Report: August 11, 2021

Auditor Information

Name: K. E. Arnold	**Email:** kenarnold220@gmail.com
Company Name: KEA Correctional Consulting LLC	
Mailing Address: P. O. Box 1872	**City, State, Zip:** Castle Rock. CO 80104
Telephone: 484-999-4167	**Date of Facility Visit:** May 11 and 12, 2021

Agency Information

Name of Agency: Community, Counseling & Correctional Services, Inc.			
Governing Authority or Parent Agency *(If Applicable)*: SAA			
Physical Address: 471 E. Mercury		**City, State, Zip:** Butte, MT 59701	
Mailing Address: SAA		**City, State, Zip:** SAA	
The Agency Is:	☐ Military	☐ Private for Profit	X☐ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal
Agency Website with PREA Information: http://www.cccscorp.com/			

Agency Chief Executive Officer

Name: Mike Thatcher	
Email: mthatcher@cccscorp.com	**Telephone:** 406-782-0417

Agency-Wide PREA Coordinator

Name: Marwan Saba	
Email: msaba@cccscorp.com	**Telephone:** 406-491-0245

PREA Coordinator Reports to: Director of Development Administration and Contract Management	**Number of Compliance Managers who report to the PREA Coordinator:** 9

Facility Information

Name of Facility: Bismarck Transition Center			
Physical Address: 2001 Lee Avenue		**City, State, Zip:** Bismarck, ND 58504	
Mailing Address (if different from above): SAA		**City, State, Zip:** SAA	
The Facility Is:	☐ Military	☐ Private for Profit	X☐ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

Facility Website with PREA Information: http://www.cccscorp.com/

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

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

X☐ ACA

☐ NCCHC

☐ CALEA

X☐ Other (please name or describe: BJA, DOCR, CPC

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

Facility Director

Name: Kevin Arthaud			
Email: karthaud@cccscorp.com		**Telephone:** 701-222-3440	

Facility PREA Compliance Manager

Name: Sheila Rahn			
Email: srahn@cccscorp.com		**Telephone:** (701) 222-3440 ext. 145	

Facility Health Service Administrator X☐ N/A

Name:

Email:	**Telephone:**

Facility Characteristics

Designated Facility Capacity:	165
Current Population of Facility:	87
Average daily population for the past 12 months:	85 (2019-2020)
Has the facility been over capacity at any point in the past 12 months?	☐ Yes X☐ No
Which population(s) does the facility hold?	☐ Females ☐ Males X☐ Both Females and Males
Age range of population:	18-65 months
Average length of stay or time under supervision	3-6 months
Facility security levels/resident custody levels	Community Custody
Number of residents admitted to facility during the past 12 months	357
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:	333
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *30 days or more:*	291
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	X☐ Yes ☐ No
Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):	☐ Federal Bureau of Prisons ☐ U.S. Marshals Service ☐ U.S. Immigration and Customs Enforcement ☐ Bureau of Indian Affairs ☐ U.S. Military branch X☐ State or Territorial correctional agency ☐ County correctional or detention agency ☐ Judicial district correctional or detention facility ☐ City or municipal correctional or detention facility (e.g. police lock-up or city jail) ☐ Private corrections or detention provider ☐Other - please name or describe: ☐ ☐ **N/A**
Number of staff currently employed by the facility who may have contact with residents:	33
Number of staff hired by the facility during the past 12 months who may have contact with residents:	5

Number of contracts in the past 12 months for services with contractors who may have contact with residents:	0
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	0
Number of volunteers who have contact with residents, currently authorized to enter the facility:	4

Physical Plant	
Number of buildings: **Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.**	2
Number of resident housing units: **Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.**	34 Dormitory Rooms
Number of single resident cells, rooms, or other enclosures:	0
Number of multiple occupancy cells, rooms, or other enclosures:	0
Number of open bay/dorm housing units:	
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	X☐ Yes ☐ No
Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	☐ Yes X☐ No

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

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

Investigations

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

Administrative Investigations	
Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?	5
When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: Select all that apply	X☐ Facility investigators ☐ Agency investigators ☐ An external investigative entity
Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)	☐ Local police department ☐ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☐X Other (please name or describe: Facility and CCCS PC ☐ ☐ N/A

Audit Findings

Audit Narrative (including Audit Methodology)

The Prison Rape Elimination Act (PREA) on-site audit of the Bismarck Transition Center (BTC) was conducted May 11 and 12, 2021 by K. E. Arnold from Castle Rock, CO, a United States Department of Justice Certified PREA Auditor for both juvenile and adult facilities. Pre-audit preparation included review of all materials and self reports electronically uploaded to an encrypted thumb drive and mailed to the Auditor's address via the United States Postal Service. The thumb drive was securely packaged in such a manner as to alert to envelope tampering.

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

On Tuesday, May 11, 2021, the Administrator, the BTC ACA Coordinator/PREA Manager, the CCCS PC, the CCCS PREA Specialist, the BTC chief of security (cos), clinical supervisor of programming, case manager supervisor, resident assistant supervisor/maintenance, and the auditor attended this meeting. The facility count on May 11, 2021 was 86 residents.

The auditor provided an overview of the audit process and advised all attendees the same would be facilitated in the least disruptive manner possible. Additionally, the auditor advised attendees of the tentative schedule(s) for the conduct of the audit.

During the on-site audit, the auditor was provided a private conference room from which to review documents and facilitate confidential interviews with staff and residents. The auditor randomly selected (from a resident roster provided by the BTC PREA Manager) and interviewed 11 random residents (with varying lengths of stay) pursuant to the random sample of residents questionnaire. As both male and female residents are housed at BTC, two of the five female residents were interviewed. Resident interviewees represented the male and female housing units.

According to the BTC PREA Manager (ACA Coordinator/PREA Manager), zero resident(s) confined at the facility during the on-site audit were Limited-English Proficient, lesbian/gay/intersex residents, or who reported a historical community/confinement setting sexual abuse during victimization/aggressor screening. While initially reported that zero transgender residents were confined at BTC, the auditor learned one interviewee is declaring as transgender. She did not self report transgender status during initial or 30-day assessments (self identified as a "cross dresser") however, she self identified as transgender as an interviewee. The auditor referred the matter to the CCCS PC and an interview with the resident subsequently followed. She is receiving all rights afforded by PREA standards.

It is noted the 11 random resident interviewees were generally questioned regarding their knowledge of a variety of PREA protections and their knowledge of reporting mechanisms available to residents for reporting sexual abuse and sexual harassment. Overall, random resident interviewees presented adequate knowledge of PREA policies and practices. Of note, the Auditor inquired as to the basis for their knowledge and random residents advised they had received training by BTC staff however, they have also received training at other North Dakota Department of Corrections and Rehabilitation (ND DOCR) facilities and/or other Pre-Release Centers, treatment facilities, etc. throughout the state of North Dakota. Additionally, all 11 random resident interviewees advised they feel sexually safe at BTC.

Twelve random staff selected by the auditor from a staff roster provided by the CCCS PC were interviewed. The random sample of staff interview guide was administered to this sample group of interviewees and interviewees were questioned regarding PREA training and overall knowledge of the agency's zero tolerance policy, reporting mechanisms available to residents and staff, the response protocols when a resident alleges abuse, and first responder duties.

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

Agency Head
Warden or Designee
PREA Coordinator (1), BTC PREA Manager (1)
Designated Staff Charged with Monitoring Retaliation (1)
Incident Review Team (1)
Human Resources (1)
Investigator (2- BTC administrative investigator and BPD criminal investigator)
SAFE/SANE Staff (Central Dakota Forensic Nurse Examiners) (1)
Victim Advocate (1)
Intake (1)
Staff Who Perform Screening for Risk of Victimization and Abusiveness (2)
Security and Non-Security Staff Who Have Acted as First Responders (one each)
Non-medical Staff Involved in Cross-Gender Strip or Visual Searches (2)
Volunteer (3)

It is noted medical and mental health staff are not employed at BTC. Accordingly, specialty interviews were not conducted during the on-site review. Additionally, the contract administrator interview was not conducted as BTC does not employ staff in that classification.

It is noted CCCS is the umbrella company for BTC.

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

LGBTI (2- one bisexual and one transgender);
Cognitively impaired (1);
Disabled (2);
Low reading (1);
Reported a sexual abuse at BTC (1).

The auditor reviewed 11 Staff Training records, 12 resident files, 11 staff HR files, 12 PREA investigative files, and other records reflected throughout the following narrative, prior to the audit, during the audit, and subsequent to completion of the same.

On May 11, 2021, the auditor was processed into the facility at the Administrative Side Entrance. As mentioned in 115.211, a PREA Compliance Acknowledgment is issued for all contractors, visitors, and volunteers each time they enter BTC. Potential entrants (inclusive of the auditor) are instructed to read this Acknowledgment and affix their signature to the same. The Acknowledgment addresses definitions of sexual abuse, sexual harassment, and voyeurism and mandatory investigation of anyone who has allegedly committed such an act, inclusive of prosecution in those instances wherein the threshold is met for a criminal act. Additionally, the same includes a certification of understanding of the requirements of PREA as scripted in the document, verbiage regarding zero tolerance towards any form of sexual abuse and sexual harassment, and verbiage regarding immediate reporting of any knowledge of sexual abuse or sexual harassment. This document serves as a constant PREA reminder to affected individuals entering the confines of BTC. When signing this document, contractors, vendors, service providers, and volunteers at BTC are likewise certifying they have familiarized and understand PREA, agreeing to abide by this law.

From 8:30AM to 9:45AM on the same date, the Administrator, BTC PREA Manager and the auditor toured the entire facility. The auditor observed, among other features, the facility configuration, location of cameras, staff supervision of offenders, unit and facility layout (inclusive of shower/toilet areas), placement of PREA posters and informational resources, security monitoring, and offender programming.

The facility is comprised of two buildings with an Administrative Area located on the First Floor of Building 1/male housing unit and a female housing unit located on the Second Floor of the same building. Building 2 (the Assessment Building) is comprised of a male housing unit on the First Floor and a small male housing unit located on the Second Floor (Men's Secure Unit). A Resident Assistant (RA) Office (the equivalent of a Control Center) is located on the First Floor of the Assessment Building. Residents are not authorized to be in the RA Office and the same is manned on a 24/7 basis.

The auditor notes female residents are geographically separated from male residents. They enter and exit the facility through a separate entrance in comparison to male residents, etc.

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

Just east of the Front Entry (First Floor), resident rooms are located along the East and South walls in an L configuration. Given the configuration and varying room sizes, many blind spots are present in the hallway outside the East rooms. It is noted a resident bathroom is located on the other side of this hallway and the same is not readily observable by either camera in view of physical barriers.

The auditor notes that two bathrooms in the female housing section require attention. While the bathroom commodes are located behind a solid door, the same are not shielded should an individual unexpectedly open the same. Accordingly, the auditor strongly recommends that a curtain fixture or partition be installed to facilitate privacy. The BTC PREA Manager will advise the auditor regarding the progress of this project when responding to other corrective action.

In regard to camera surveillance, some modifications, as articulated throughout this report, have enhanced blind spot maintenance. The camera system upgrade referenced in the previous Final PREA Report has not been installed. During the facility tour, the auditor and the Administrator discussed strategic placement of a series of mirrors to enhance observation. The mirrors have been ordered with installation pending upon receipt of the physical product.

The auditor toured the two Recreation Areas, determining there are sufficient cameras. The Administrator explained staff always supervise the Recreation Yards when female residents use the same.

In the TSU, an Emergency Grievance Box is mounted on the wall and emergency grievances were readily available.

At maximum capacity, the BTC is an extremely busy facility with significant movement on a daily basis. Resident movement to and from work in the community, programs, medical appointments in the community, and community activities is abundant and appears to be monitored and tracked in an effective manner.

It is noted the auditor telephonically spoke with a representative from the Abused Adult Resource Center (AARC) and he/she was aware of no particular sexual safety issues at BTC in terms of an inordinate number of sexual abuse or sexual harassment allegations, etc. AARC is a community sexual abuse advocacy organization with whom BTC has an MOU for provision of advocacy services.

Facility Characteristics

The Bismarck Transition Center (BTC) is a comprehensive, community-based correctional program designed to help eligible, non-violent offenders transition back into the community. It provides the opportunity to develop necessary skills that aid male and female offenders in obtaining essentials such as employment and housing once they are released into society. The program provides residents with a full-range of treatment services that decrease the likelihood of recidivism upon release.

Community, Counseling, and Correctional Services, Inc. (CCCS) in partnership with the North Dakota Department of Corrections and Rehabilitation opened BTC in August 2002. The facility was renovated by a group of private investors and is now owned by CCCS. BTC is the only CCCS correctional facility in North Dakota that is accredited by the American Correctional Association.

Program objectives are as follows:

Provide residents with a structured living and work environment through staff supervision and monitoring;

Provide residents with a Case Manager responsible for development and constant assessment of an individualized case management plan;

Provide designated residents with Cognitive Behavioral Therapy and/or Substance Abuse Services;

Provide residents with weekly individual contact with their designated Case Manager;

Provide residents with evidence based core correctional programming, which includes the eight principles developed by the Transition from Prison to Community Initiative, in collaboration with the ND DOCR;

Provide residents with community based support groups to be held within the facility;

Provide residents opportunities to access community based programming, including spiritual and religious activities;

Provide residents the opportunity to participate in recreational activities;

Provide residents opportunities for reintegration into their family and community, which includes weekly visitation and passes;

Provide opportunities for full-time employment and/or continued education.

Summary of Audit Findings

Standards Exceeded

Number of Standards Exceeded: 3
List of Standards Exceeded: 115.211, 115.231, and 115.252

Standards Met

Number of Standards Met: 38

Standards Not Met

Number of Standards Not Met: 0
List of Standards Not Met: (115.288 is compliant prior to completion of the 2021 Interim Audit Report)

PREVENTION PLANNING

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

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

115.211 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? X□ Yes □ No

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

115.211 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator? X□ Yes □ No

- Is the PREA Coordinator position in the upper-level of the agency hierarchy? X□ Yes □ No

- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities?
  X□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

Pursuant to the Pre-Audit Questionnaire (PAQ), the Administrator self reports the agency has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment in facilities it operates directly or under contract. The Administrator further self reports the facility has a written policy outlining how it will implement the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment.

The facility has a written policy which includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment and the policy includes sanctions for those found to have participated in prohibited behaviors. Additionally, the policy includes a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents.

BTC Policy 13.1 entitled PREA General Requirements, sections entitled Purpose and Policy address 115.211(a). Pages 1-10 of the same policy also address 115.211(a).

Pursuant to the PAQ, the Administrator self reports the agency employs or designates an upper-level, agency-wide PREA Coordinator, CCCS PREA Coordinator and Program Compliance (CCCS PC), who has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its community confinement facilities. The Administrator self reports the CCCS PC is in the agency's organizational structure and the auditor verified the same pursuant to review of the CCCS Organi-

zational Chart. The CCCS PC reports directly to the Director of Development Administration and Contract Management, who reports directly to the CCCS Chief Executive Officer (CEO). The CCCS PC has direct access to company executive staff.

The auditor notes the American Correctional Association [(ACA) Coordinator/PREA Manager (PM)] ACA/PM serves as the PREA Manager (PCM) at BTC and she does have sufficient time and authority to develop, implement, and oversee facility efforts to comply with the PREA standards at BTC. She is likewise included in the facility organizational chart hierarchy, directly reporting to the Administrator.

BTC Policy 13.1 entitled Prison Rape Elimination Act, pages 6 and 7, section IV(A)(1)(a-d) addresses 115.211(b).

The CCCS PC asserts he has sufficient time to manage all of his PREA- related duties. He oversees eleven facilities with collateral Compliance Manager duties. Nine PCMs and one Compliance/PREA Specialist report to him and facilitate PREA- related duties at the respective facilities. As PC, he identifies the issue(s) and assesses whether policy development/modification is necessary. Review of the Staffing Plan is a critical step when confronted with any PREA issue, as well as, review of camera needs and placements.

The BTC PCM asserts she uses effective time management skills to manage all daily duties, inclusive of PREA. She uses other staff to exercise quality control with respect to PREA- related matters. In an effort to monitor both PREA and ACA expectations and requirements, she walks and talks almost daily with both staff and residents. Daily monitoring results in more efficient management of both programs.

As a point of interest, a PREA Compliance Acknowledgment is issued to all contractors, visitors, and volunteers each time they enter BTC. Potential entrants are instructed to read this Acknowledgment and affix their signature to the same. The Acknowledgment addresses definitions of sexual abuse, sexual harassment, and voyeurism and mandatory investigation of anyone who has allegedly committed such an act, inclusive of prosecution in those instances wherein the threshold is met for a criminal act. Additionally, the same includes a certification of understanding of the requirements of PREA as scripted in the document, verbiage regarding zero tolerance towards any form of sexual abuse and sexual harassment, and verbiage regarding immediate reporting of any knowledge of sexual abuse or sexual harassment. This document serves as a constant PREA reminder to affected individuals entering the confines of BTC.

In view of the above, the Auditor has determined that the BTC program exceeds Standards 115.211 and 115.232 based on this practice. An important segment of PREA familiarity is ingrained in potential entrants each and every time they visit the facility.

In view of the above, the auditor finds BTC exceeds standard expectations with respect to 115.211.

Standard 115.212: Contracting with other entities for the confinement of residents

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

115.212 (a)

- If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's obligation to comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) □ Yes □ No X□ NA

115.212 (b)

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

115.212 (c)

- If the agency has entered into a contract with an entity that fails to comply with the PREA standards, did the agency do so only in emergency circumstances after making all reasonable attempts to find a PREA compliant private agency or other entity to confine residents? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.) □ Yes □ No X□ NA

- In such a case, does the agency document its unsuccessful attempts to find an entity in compliance with the standards? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.) □ Yes □ No X□ NA

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Administrator self reports CCCS and BTC do not contract with other facilities or companies to house residents designated for confinement at BTC. The auditor's research and informal interview with the CCCS PC and Administrator validate the same. Memorandums dated 2018, 2019, and 2020-2021 also validate the same.

Given the lack of evidence substantiating non-compliance with 115.212, the auditor finds BTC substantially compliant with the same.

Standard 115.213: Supervision and monitoring

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

115.213 (a)

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

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The physical layout of each facility? X□ Yes □ No

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

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

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors? X□ Yes □ No

115.213 (b)

- In circumstances where the staffing plan is not complied with, does the facility document and justify all deviations from the plan? (N/A if no deviations from staffing plan.)
  X□ Yes □ No □ NA

115.213 (c)

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the staffing plan established pursuant to paragraph (a) of this section? X□ Yes □ No

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

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the facility's deployment of video monitoring systems and other monitoring technologies? X□ Yes □ No

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the resources the facility has available to commit to ensure adequate staffing levels? X□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Administrator self reports the agency develops and documents a staffing plan that provides for adequate levels of staffing, and where applicable, video monitoring to protect residents against sexual abuse. The Director self reports the average daily number of residents since the last PREA audit is 140 and the average daily number of residents on which the staffing plan is predicated is 140.

BTC Policy 13.1 entitled PREA General Requirements, page 7, section IV(A)(5) addresses 115.213(a).

As the auditor toured the facility, he noted several instances of "blind spots" (as previously referenced in this report) that may impede supervision. The auditor also notes that strategies to offset blind spots with staff supervision and rounds are noted in the staffing plans, as well as, annual PREA reports. During the facility tour, the auditor, the Administrator, and the PCM discussed blind spots and a temporary solution in addition to the aforementioned staffing strategies. The auditor recommends the use of additional mirrors where cameras do not provide coverage. As an example, in the Men's Secure Unit (MSU), a short segment of hallway is not covered and accordingly, some rooms are not addressed. The auditor recommends placement of a corner mirror in that area to provide additional visibility to staff making security rounds.

According to the Administrator, there is a BTC Staffing Plan that is updated annually. He advises that staffing levels are adequate to protect residents against sexual abuse. Staffing levels are based on resident population, risk factors, disabilities, Mental Health, previous PREA incidents, physical plant concerns, language barriers, and camera surveillance. The Staffing Plan is documented and maintained by the Administrator/PREA Manager.

The Administrator further relates the physical layout of the facility, the composition of the resident population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, and any other relevant factors are considered. All of these considerations are articulated in the preceding paragraph.

Compliance with the Staffing Plan is accomplished pursuant to review of the Chief of Security Shift Report. However, we are now using the Exception or Deviation Form to document. Supervisors are reporting.

It is noted the auditor reviewed Deviation Forms and determined that accountability for deviation from the Staffing Plan is isolated to instances wherein insufficient female staff were on post. The Administrator confirmed the same during a separate conversation.

The Administrator (also the PREA Manager) also advised that when assessing adequate staffing levels and the need for video monitoring, blind spots, the linear configuration of the facility, and resident schedules for movement throughout facility are considered. Resident offenses, frequency and nature of disciplinary reports. and locations at which incidents occurred, as well as, where incidents happened, any patterns, and root causes are also considered. Finally, any other relevant factors are considered.

According to the Administrator, there is a BTC Staffing Plan that is updated annually. He advises that staffing levels are adequate to protect residents against sexual abuse. Staffing levels are based on resident population, risk factors, disabilities, Mental Health, previous PREA incidents, physical plant concerns, language barriers, and camera surveillance. The Staffing Plan is documented and an electronic copy is available on the Shared Drive, available to the BTC Management Team, IT, CCCS PC, and CCCS administration. A hard copy is maintained by the Administrator and CCCS PC.

The Administrator further relates the physical layout of the facility, the composition of the resident population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, and any other relevant factors are considered. All of these considerations are articulated as follows:

Physical layout of the facility- the facility is staffed on a 24/7 basis. Male and female staff are scheduled on all shifts. Staff saturation and intensity are increased accordingly to compensate during those times of high resident traffic. As previously reference, staff coverage is creatively designed to address blind spots in conjunction with technology/mirrors/etc.

Composition of the resident population- The LGBTI population is minimal and negligible in terms of concerns. Gang members and affiliates are likewise minimal. While there is a substantial number of aggressors within the resident population, separation has not been a problem. Likewise, ethnic balance has not been problematic.

Prevalence of substantiated and unsubstantiated incidents- In comparison to previous years, the number of incidents is decreasing. While not required pursuant to the Community Confinement Standards, we have implemented unannounced sexual safety rounds and the same appears to be beneficial. Close monitoring of Sexual Abuse Response Team meetings and reports allows for effective monitoring of trends and completion of recommendations, if feasible.

No other factors are identified.

The auditor notes the PCM articulated nearly the same responses regarding the four considerations mentioned above.

Compliance with the Staffing Plan is accomplished by the Chief of Security (COS) monitoring of the daily Security Shift Report. He ensures the Administrator remains in the loop regarding call-offs, etc. The Case Manager Supervisor (CMS), Food Service Director (FSD), and Treatment Director (TD) likewise appraise the Administrator regarding their staff. On a weekly basis, the aforementioned department heads and the Administrator discuss staffing for the next week.

The Exception or Deviation Form is used to document post shortages and strategy(ies) used to offset the vacancy. Of note, zero posts have remained vacant throughout the audit period.

Pursuant to the PAQ, the Administrator self reports in circumstances where the staffing plan is not complied with, the facility documents and justifies all deviations from the plan.

The Administrator further self reports that 1.Sick call-off; 2. shortage of same gender staff; 3. vacation; 4. training; 5. transportation; and 6. unforeseen circumstances are the six most common reasons for deviating from the staffing plan. The auditor notes, however, that zero PREA essential posts remained vacant throughout the audit period. Accordingly, there is no evidence of deviation from the staffing plan.

BTC Policy 13.1 entitled PREA General Requirements, page 7, section IV(A)(6) addresses 115.213(b).

Pursuant to the PAQ, the Administrator self reports that at least once every year, the facility reviews the staffing plan to assess whether adjustments are needed to:

The staffing plan;
Prevailing staffing patterns;
The deployment of video monitoring systems and other monitoring technologies; or
The allocation of facility/agency resources to commit to the staffing plan to ensure compliance with the same.

BTC Policy 13.1 entitled PREA General Requirements, page 7, section IV(A)(7) addresses 115.213(c).

According to the PCM, the Staffing Plan is reviewed on, at least, an annual basis and she is consulted regarding any necessary adjustments.

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

Standard 115.215: Limits to cross-gender viewing and searches

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

115.215 (a)

- Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?
  X□ Yes □ No

115.215 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches of female residents, except in exigent circumstances? (N/A if the facility does not have female residents.)
  X□ Yes □ No □ NA

- Does the facility always refrain from restricting female residents' access to regularly available programming or other outside opportunities in order to comply with this provision? (N/A if the facility does not have female residents.) X□ Yes □ No □ NA

115.215 (c)

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

- Does the facility document all cross-gender pat-down searches of female residents? (N/A if the facility does not have female residents). X□ Yes □ No □ NA

115.215 (d)

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

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

- Does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? X□ Yes □ No

115.215 (e)

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status? X□ Yes □ No

- If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner? X□ Yes □ No

115.215 (f)

- Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? X□ Yes □ No

- Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? X□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Administrator self reports that facility staff do not conduct cross gender strip or cross-gender body cavity searches of residents. However, the following policy clearly stipulates the same can be conducted in exigent circumstances. The Administrator further self reports zero strip or cross-gender visual body cavity searches of residents were conducted at BTC during the last 12 months.

BTC Policy 13.1 entitled PREA General Requirements, page 7, section IV(A)(8) addresses 115.215(a).

The non-medical staff involved in cross-gender strip or visual searches interviewee reports introducing drugs in the rectum qualifies as an exigent circumstance, requiring a cross-gender strip and/or visual body cavity search.

The auditor has found no evidence of cross-gender strip or visual searches conducted by non-medical staff at BTC during the last 12 months. Clearly, while allowed under exigent circumstances, staff are dissuaded from performing such searches as reflected in the afore-cited policy.

Pursuant to the PAQ, the Administrator self reports that the facility does not allow cross-gender pat down searches of female residents. However, the following policy clearly stipulates the same can be conducted in exigent circumstances. The Administrator further self reports the facility does not restrict female residents' access to regularly available programming or other outside opportunities in order to comply with this provision and there has been zero pat-down searches of female residents conducted by male staff during the last 12 months.

BTC Policy 13.1 entitled PREA General Requirements, pages 7 and 8, section IV(A)(9) and (10) addresses 115.215(b).

The auditor has not discovered any incident wherein such programming or opportunities were canceled based on the circumstances cited in the provision.

Eleven of the twelve random staff interviewees report access to programs or outside activities would not be restricted if insufficient female staff were available to conduct pat-down searches of female residents. Interviewees report female staff are either always on staff or available pursuant to on-call. Similarly, two of two random female residents of the 11 random resident interviewees report that the afore-described program(s) and activities would not be canceled as there are always female staff on shift.

Pursuant to the PAQ, the Administrator asserts facility policy requires that all cross-gender strip and cross-gender visual body cavity searches are documented. Likewise, facility policy requires that all cross-gender pat down searches of female residents are documented.

BTC Policy 13.1 entitled PREA General Requirements, page 8, section IV(A)(11) addresses 115.215(c).

The auditor finds no evidence of the conduct of cross-gender strip searches/visual body cavity searches/ or cross-gender pat searches of female residents at BTC during the audit period.

Pursuant to the PAQ, the Administrator asserts that the facility has implemented policies and procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstance or when such viewing is incidental to routine room checks (inclusive of viewing by cameras). Policies and procedures also require staff of the opposite gender to announce their presence when entering a resident housing unit.

BTC Policy 13.1 entitled PREA General Requirements, page 8, section IV(A)(12) and (13) addresses 115.215(d).

All 11 random resident interviewees advised that all opposite gender staff announce their presence prior to entering their housing area and/or bathrooms. Minimally, prior to entering their room or the bathroom, opposite gender staff knock on the door, announce gender, generally wait a short period of time, and then enter.

All 11 random resident interviewees report they are never naked in full view of opposite gender staff (not including medical staff such as doctors, nurses) when toileting, showering, or changing clothing.

All 12 random staff interviewees confirmed the random resident statements, advising that they announce themselves when entering a unit and they knock on the door, announce gender, pause, and then enter.

During the facility tour, the auditor noted no instances either during the facility tour or throughout the duration of the on-site audit wherein opposite gender staff failed to announce their presence (by gender) whenever they entered a housing area.

Pursuant to the PAQ, the Administrator self reports the facility has a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. No such searches were facilitated in the last 12 months.

BTC Policy 13.1 entitled PREA General Requirements, page 8, section IV(A)(11)(a)(iii) addresses 115.215(e).

All 12 of the random staff interviewees report they are aware of the policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining that resident's genital status. The transgender resident interviewee reports she has no reason to believe she has been strip searched for the sole purpose of determining genitalia.

Pursuant to the PAQ, the Administrator asserts that 100% of security staff have received training on conducting pat-down searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs. As a matter of fact, all BTC staff have been properly trained as previously indicated.

BTC Policy 13.1 entitled PREA General Requirements, page 9, section IV(A)(14)(a) addresses 115.215(e).

The auditor's review of a PREA Resource Center (PRC) video entitled Guidance on Cross-Gender and Transgender Pat Searches regarding the conduct of cross-gender pat down searches and searches of transgender/intersex residents in a professional and respectful manner reveals substantial compliance with 115.215(f). Pursuant to the relevant training plan, the LGBTI Gender Identity and Gender Expression, Housing, Programs and Searches policy is also addressed during the training. Cross-gender pat-down searches and searches of transgender/intersex residents in a professional and respectful manner training is facilitated in the Restraints and Searches session during Pre-Service and annual In-Service training.

The auditor's review of two 2020 Orientation and 10 In-Service Cross-Gender and Transgender Pat Searches Staff Development and Training Record Forms reveals requisite training was provided to BTC staff. In addition to the above, the auditor's review of the same form dated January 5, 2021 reveals one staff member completed the class.

Clearly, requisite training is provided during both pre-service and in-service training. The auditor's on-site review of 10 random staff training files reveals requisite training was provided in six cases (Orientation and/or Pre-Service). At least two years of requisite In-Service training were reviewed with respect to applicable cases.

According to the 12 random staff interviewees, they have been trained regarding cross-gender pat searches and searches of transgender and intersex residents in a professional and respectful manner. All interviewees report they received this training during 2020 and 2021 however, such training is provided during annual PREA and Orientation training. This training was provided by a combination of instructor-led, presentation of a video, Power Point presentation, and physical demonstration.

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

Standard 115.216: Residents with disabilities and residents who are limited English proficient

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

115.216 (a)

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing? X□ Yes □ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision? X□ Yes □ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities? X□ Yes □ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities? X□ Yes □ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities? X□ Yes □ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.) X□ Yes □ No

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

- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? X□ Yes □ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? X□ Yes □ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? X□ Yes □ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision? X□ Yes □ No

115.216 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient? X□ Yes □ No

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

115.216 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.264, or the investigation of the resident's allegations? X□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Administrator self reports the agency has established procedures to provide disabled residents equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse/harassment.

BTC Policy 14.3 entitled Intake Screening, pages 2 and 3, section II(A)(2)(a-c) and (3) addresses 115.216(a).

Pursuant to a Memorandum Of Understanding (MOU) with a Special Education Teacher, she provides services to BTC with respect to the requirements of 115.216(a). The auditor's review of the MOU reveals substantial compliance with 115.216(a).

In addition to the above, the auditor reviewed the contract between BTC and the North Dakota Department of Corrections and Rehabilitation, determining that BTC staff can deny NDDCR inmates based on security concerns. This provision is scripted at page 10, section 15(H)(5) of the aforementioned contract.

The auditor's review of memorandums dated 2018, 2019, and 2020/2021 reveals specialized interpreter(s) were not used during any of the aforementioned audit years.

The auditor's review of the BTC PREA Handbook reveals the same is written in a format, seemingly readable and facilitation of comprehension by the vast majority of the resident population.

The Agency Head asserts the agency has established procedures to provide residents with disabilities and family members who are limited English proficient (LEP) equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse/harassment. Pursuant to

contract with Language Line, compliance regarding LEP residents is accomplished. In terms of MOUs for cognitively impaired, low functioning residents, there is a Corporate agreement with a Special Education Teacher to provide services to this population, when necessary.

The four residents with disabilities (one with low reading, two disabled, and one cognitively impaired) interviewees assert the facility provides information about sexual abuse/harassment they are able to understand.

The auditor notes posters are positioned at reasonable heights for physically disabled resident review. Additionally, printed materials appear to be written at a reading level and font appropriate to the resident population.

Pursuant to the PAQ, the Administrator self reports the agency has established procedures to provide residents with limited English proficiency equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

BTC Policy 14.3 entitled Intake/Screening, page 3, section II(A)(3) addresses 115.216(b).

The auditor's review of the Language Link contract and instructions reveals substantial compliance with 115.216(b). Finally, the auditor's review of the BTC PREA Handbook reveals the same is presented in English.

At the time of the on-site audit, the PCM reported zero LEP residents were confined at BTC.

Pursuant to the PAQ, the Administrator self reports agency policy prohibits use of resident interpreters, resident readers, or other types of resident assistants, except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties, or the investigation of the resident's allegations. The Administrator further self reports the facility does not document the limited circumstances in individual cases where resident interpreters, readers, or other types of resident assistants are used and such scenarios are disallowed pursuant to company policy. Upon further inquiry, the auditor learned such incidents would be documented if facilitated in accordance with the parameters of 115.216(c). Finally, in the last 12 months, there were no instances wherein resident interpreters, readers, or other types of resident assistants have been used and it was not the case that an extended delay in obtaining another interpreter could compromise the resident's safety, the performance of first response duties, or the investigation of the resident's allegations.

BTC Policy 14.3 entitled Intake/Screening, page 3, section II(A)(3) addresses 115.216(c).

All 12 random staff interviewees report resident interpreters or translators can be used. Only one of the 12 interviewees did not know the circumstances under which such translation can occur. All random staff interviewees advised resident interpreters/translators had not been used under these circumstances during the last 12 months.

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

Standard 115.217: Hiring and promotion decisions

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

115.217 (a)

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? X□ Yes □ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? X□ Yes □ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? X□ Yes □ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? X□ Yes □ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? X□ Yes □ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? X□ Yes □ No

115.217 (b)

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

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

115.217 (c)

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

- Before hiring new employees who may have contact with residents, does the agency, consistent with Federal State, and local law: Make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse? X□ Yes □ No

115.217 (d)

- Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents? X□ Yes □ No

115.217 (e)

- Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees? X□ Yes □ No

115.217 (f)

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions? X□ Yes □ No

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees? X□ Yes □ No

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

115.217 (g)

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

115.217 (h)

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Administrator self reports agency policy prohibits hiring or promoting anyone who may have contact with residents and prohibits enlisting the services of any contractor who may have contact with residents who:

Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997);
Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or
Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section.

CCCS Policy 1.3.1.12 entitled Employee, Contractor and Volunteers Clearance Check, pages 1 and 2, section IV(B) addresses 115.217(a).

The auditor's review of fifteen 2019 and fifteen 2020 Disclosure of PREA Employment Standards Violation forms (these forms are completed annually by BTC staff) reveals substantial compliance with 115.217(a), (b), and (f). The employee completes the form, checking the correct boxes in response to 115.217(a) and (b) issues. Finally, the employee signs and dates each form. Four 2018 forms were completed, signed and dated in conjunction with promotions.

Of note, the auditor's review of 2018, 2019, and 2020 promotion applications and Interview Response Rating Forms reveals 115.217(a) and (b) questions are asked in both formats. Additionally, the auditor's review of criminal background record checks related to these individuals reveals absence of 115.217(a) and (b) information.

The auditor's on-site review of ten employee personnel files, four of which pertain to employees hired since the last PREA audit, particularly assessing whether the 115.217(a) and (b) questions were asked prior to or on the date of hire, reveals substantial compliance with 115.217(a) and (b). No violations of either policy or standard were discovered by the auditor.

According to the Administrator, zero contractors are on board at BTC.

Pursuant to the PAQ, the Administrator asserts agency policy shall consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.

CCCS Policy 1.3.1.2 entitled PREA, page 7, section 1V(b) entitled Hiring and Promotion Decisions addresses 115.217(b).

Pursuant to the auditor's review of ten employee personnel files, he found no evidence of contact with previous institutional employers regarding incidents of sexual harassment. Additionally,the auditor has not been provided with any documentation to substantiate review and consideration of the same.

According to the Human Resources (HR) Director interviewee, prior incidents of sexual harassment are considered when determining whether to hire or promote anyone, or to enlist the services of any contractor who may have contact with residents.

Pursuant to the PAQ, the Administrator asserts agency policy requires that before it hires any new employees who may have contact with residents, it (a) conducts criminal background record checks, and (b) consistent with federal, state, and local law, makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. The Administrator further asserts that five staff were hired within the past 12 months who may have contact with residents who have had criminal background record checks.

CCCS Policy 1.3.1.2 entitled PREA, page 7, section 1V(c) entitled Hiring and Promotion Decisions addresses 115.217(c).

According to the HR Director interviewee, criminal record background checks are conducted regarding all newly hired employees who may have contact with residents and all employees who are considered for promotions. Additionally, the interviewee asserts such checks are likewise conducted regarding any contractor who may have contact with residents. Such checks include administrative and/or civil adjudications.

The auditor's review of one completed 2021 prior institutional employer Request for Information form reveals substantial compliance with 115.217. Prior institutional employer checks were not completed in one of the on-site random staff file reviews.

In view of policy requirements, interview results, and the fact that evidence reveals prior institutional employer checks, pursuant to 115.217(c), were conducted in half of the applicable files reviewed, the auditor finds BTC substantially compliant with 115.217(c).

The auditor's review of four employee HR files applicable to employees hired during this audit period reveals criminal background record checks were facilitated prior to the date of hire in each case.

Pursuant to the PAQ, the Administrator asserts agency policy requires that a criminal background record check be completed before enlisting the services of any contractor who may have contact with residents. The Administrator further self reports that during the last 12 months, zero background checks were conduct-

ed for contract staff engaged in contracts for services at BTC. Zero contractors, within the meaning of 115.217(d) and 115.232 are utilized at BTC.

CCCS Policy 1.3.1.12 entitled Employee, Contractors and Volunteers Clearance Check, page 1, section IV(A)(2) addresses 115.217(d).

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

CCCS Policy 1.3.1.12 entitled Employee, Contractors and Volunteers Clearance Check, page 2, section IV(C) addresses 115.217(e).

The auditor's review of one five-year criminal background record check reveals substantial compliance with 115.217(e).

According to the CCCS HR Director, five-year re-investigation tracking is accomplished by Corporate. They alert the facility of the need for 5-year re-investigation. Facility staff order re-investigation.

The auditor's review of three 2019 five-year re-investigations reveals substantial compliance with 115.217(e). The re-investigations were facilitated in a timely manner and there is no evidence of 115.217(a) convictions.

CCCS Policy 1.3.5.12 entitled PREA, page 7, section 115.217(f) addresses 115.217(f).

The auditor's review of three of four new employee files for staff hired during the audit period reveals the requisite 115.217(a) and (b) questions were asked prior to hire. It is also noted that requisite questions are referenced in employment applications.

The auditor's review of 10 random staff HR files reveals all staff completed Disclosure of PREA Employment Standards Violation forms on an annual basis. The forms were completed as described in the narrative for 115.217(a).

The continuing affirmative duty to disclose any such previous misconduct verbiage is also reflected on these forms.

The HR Director advises that all applicants and employees who may have contact with residents are asked about previous misconduct described in section a (above) in written applications for new hires or promotions, and in any interviews or written self-evaluations conducted as part of reviews of current employees. A re-investigation is completed for all promotions. In addition to the above, employees are subjected to a continuing affirmative duty to disclose any such previous misconduct.

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

CCCS Policy 1.3.1.2 entitled Recruiting and Selection, pages 2 and 3, section IV(B)(3) addresses 115.217(g).

The auditor notes the Disclosure of PREA Employment Standards Violation forms (these forms are completed annually by BTC staff) reveals substantial compliance with 115.217(g). The employee completes the form, checking the correct boxes in response to 115.217(a) and (b) issues. Finally, the employee signs and dates each form.

The auditor notes a caveat is included on this form wherein the employee is advised that material omissions or provision of false information regarding 115.217(a) and (b) misconduct are grounds for termination. A discussion regarding the auditor's findings regarding this form is articulated in the narrative for 115.217(a).

CCCS Policy 1.3.5.12 entitled PREA, page 7, section 115.217(h) addresses 115.217(h).

According to the HR Director, when a former employee applies for work at another institution and upon request from that institution, the facility provides information on substantiated allegations of sexual abuse or sexual harassment involving the former employee.

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

Standard 115.218: Upgrades to facilities and technologies

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

115.218 (a)

- If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.) □ Yes □ No X□ NA

115.218 (b)

- If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.) X□ Yes □ No □ NA

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Administrator asserts that the facility has not acquired a new facility or made a substantial expansion or modification to existing facilities since the last PREA audit. This assertion was validated by the auditor during the facility tour.

Pursuant to the PAQ, the Administrator self reports the facility has installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since the last PREA audit.

During 2019, three cameras were replaced when existing cameras failed. The monitor in the RA office was also replaced when it failed. One camera was moved from the outside of the Administrative area to the inside Administrative area. This was changed due to an incident that occurred with a staff member and resident. The camera was placed in view of staff and residents when administrating medications and any other activity in the Administration area.

During 2020/2021, one camera was re-positioned in the WSU to be more observable of the RA desk and residents approaching the desk.

In addition to the above, one camera was removed from the old laundry room on second floor back building to the hallway on the second floor facing the door leading to the WSU. All movements were completed to enhance resident sexual safety at BTC.

The auditor's review of a price quotation dated September 13, 2017 reveals an effort to enhance sexual safety following the last PREA audit.

The Administrator self reports zero camera enhancements were effected during the audit period. However, some cameras have been replaced and some have been moved and/or repositioned.

During the facility tour, the auditor identified some areas wherein additional monitoring coverage should be thoroughly evaluated based on the configuration of the physical plant. In the alternative and as an immediate action, the auditor recommends 180 degree mirrors be installed in several areas. Such areas were discussed with the Administrator.

In view of the above, the auditor finds BTC substantially compliant with 115.218.

RESPONSIVE PLANNING

Standard 115.221: Evidence protocol and forensic medical examinations

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

115.221 (a)

- If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) X□ Yes □ No □ NA

115.221 (b)

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) X□ Yes □ No □ NA

- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) X□ Yes □ No □ NA

115.221 (c)

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

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

- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? X□ Yes □ No

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

115.221 (d)

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

- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? (N/A if agency *always* makes a victim advocate from a rape crisis center available to victims.) X□ Yes □ No □ NA

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

115.221 (e)

- As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews? X□ Yes □ No

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

115.221 (f)

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

115.221 (g)

- Auditor is not required to audit this provision.

115.221 (h)

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Administrator self reports that the facility is responsible for conducting administrative sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). The Administrator further self reports that the Bismarck Police Department (BPD) conducts criminal investigations. Pursuant to 2019, 2020, and 2021 Memorandums of Understanding (MOU) between the BTC Administrator and the BPD Chief of Police, BPD criminal investigators facilitate criminal investigations of sexual abuse at BTC. 115.221(b) investigative protocols are employed by BPD criminal investigators in the event of a criminal investigation.

In terms of a uniform evidence protocol, BTC Policy 13.11 entitled Coordinated Response/Staff First Response Duties, pages 1 and 2, section II(2)(A)(1-13) addresses 115.221(a).

Eight of the 12 random staff interviewees articulated the evidence protocol requires that the victim and perpetrator be separated, the crime scene is secured, the victim is asked not to destroy physical evidence by brushing teeth, changing clothes, showering, eating, drinking, urinating, and defecating. Staff are to ensure the perpetrator does not destroy evidence as stipulated in the preceding sentence. Of the 8 interviewees, many report the perpetrator would be placed in a sterile and secure room near the Resident Assistant (RA) Office. This is commensurate with the provisions of the aforementioned policy.

All 12 random staff interviewees were able to identify at least one of the five administrative sexual abuse investigators at BTC, as well as BPD, as the criminal investigating agency.

Pursuant to the PAQ, the Administrator self reports that youth are not housed at BTC. The Administrator further self reports that the protocol was adapted from or otherwise based on the most recent edition of the DOJ's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents", or similarly comprehensive and authoritative protocols developed after 2011.

It is noted that forensic medical examinations and evidence collection are not facilitated by BTC staff or at BTC.

Zero forensic medical examinations were facilitated during the audit period.

Pursuant to the PAQ, the Administrator self reports that the facility offers to all residents who experience sexual abuse access to forensic medical examinations. The Administrator further self reports that forensic medical examinations are offered without financial cost to the victim. Forensic examinations are facilitated by SAFE/SANE Nurses at the two hospitals used by BTC.

When SAFE/SANEs are not available, a qualified medical practitioner may perform forensic medical examinations or the examination may be delayed pending SANE availability. The facility does document efforts to provide SANE/SAFE Nurse forensic examinations. During the last 12 months, zero forensic medical examinations were conducted.

BTC Policy 14.5 entitled Medical and Mental Health, page 3, section II(C)(1) addresses 115.221(c).

The SANE interviewee, Bismarck Site Manager, asserts the Central Dakota Forensic Nurse Examiners are responsible for forensic examinations of BTC residents. Forensic examinations are facilitated at either St. Alexius or Sanford hospital be a group of five on-call SANE nurses. These nurses provide forensic examination coverage on a 24/7 basis.

In North Dakota, sexual abuse evidence can be processed for up to 96 hours from the time of the assault. If, for some absolute emergency, the SANE is not available, the examination is delayed pending availability. Generally, emergency room doctors and nurses may be untrained with respect to evidence collection.

A urinary pregnancy test is offered in the event of vaginal penetration. If the test is positive, the result may not be an indicator of pregnancy as the result of a recent abuse, given the incubation period.

Based on the circumstances, two prophylactic antibiotics are offered in conjunction with the forensic examination. Patients are admonished to follow-up with testing within two weeks.

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

The auditor's review of 2018, 2019, 2020, and 2021 MOUs between BTC and the Abused Adult Resource Center (AARC) reveals substantial compliance with 115.221(d).

The auditor interviewed a VA (a BTC employee assigned to the North Dakota State Penitentiary) and the Regional Sexual Assault Response Team (a task force). The Regional Sexual Assault Response Team is comprised of law enforcement representatives, AARC representatives, and prosecutor's offices.

She advises she has been a VA for eleven years with the North Dakota Council on Abused Women Services. She participated in a 40 hour North Dakota VA Training and did receive a Certificate for this training. She and all AARC VAs are certified.

She is a key player in activation of VA services at BTC. The BTC Administrator activates the interviewee and she reports to the appropriate hospital. Hospital staff simultaneously contact AARC to activate a community based VA. Subsequently, the AARC VA and the interviewee collaborate regarding services during the forensic examination and investigatory interviews.

The auditor notes follow-up is scheduled by the interviewee, as opposed to, AARC VAs. Additionally, the interviewee provides initial crisis counseling to the victim.

The auditor reviewed a finalized and signed MOU with the Abused Adult Resource Center (AARC) dated April 5, 2021 which is signed and dated by both the BTC Administrator and AARC Executive Director. It is noted that the MOU, covering the provision of VA services at and for BTC, is in force and effect.

The auditor has determined there has been substantial compliance with this provision throughout the audit period. VA services have been readily available, if required.

The PCM reports BTC is engaged in an MOU with AARC for the purpose of facilitation of 115.221(d) and (e) VA services. The interface between the VA interviewee and AARC is articulated above. Credentialing, as applicable to AARC VAs and the VA who is also employed at BTC, is both addressed on the AARC website and the above narrative.

The one resident who reported a sexual abuse interviewee reports that he did not talk to a VA after reporting a sexual abuse. Of note, this resident was not referred for a forensic examination as the result of the fact pattern. Additionally, he did not request VA services as articulated at 115.221(e). He was offered the opportunity to meet with mental health staff however, he refused the same.

As reflected above, the specifics of 115.221(d) are met as requisite protocols are in place. There is no evidence of non-compliance with 115.221(d).

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

The auditor's review of 2018, 2019, 2020, and 2021 MOUs between BTC and AARC reveals substantial compliance with 115.221(e), with the exception of requests for VA assistance during investigatory interviews. As reflected in the literal interpretation of 115.221(e), provision of a VA, if requested by the victim during investigatory interviews, is likewise required pursuant to standard provision.

In view of the above, the auditor finds BTC non-compliant with 115.221(e) and accordingly, a 180-day corrective action period is imposed. The corrective action due date is December 13, 2021.

To demonstrate institutionalization and therefore, compliance with 115.221(e), the PM, in conjunction with the Administrator, will add a provision to the AARC MOU addressing provision of VA services during investigatory interviews. A copy of the amended MOU will be provided to the auditor for review and inclusion in the audit file. Relevant stakeholders (staff) will then be trained regarding the nuance of the amended MOU to ensure understanding. Additionally, the amended MOU will be shared with and discussed with BPD representatives.

The PM will provide to the auditor a copy of training documents certifying staff review and understanding of the amended MOU. Additionally, a memorandum or email will be provided demonstrating completion of contact with and/or training with BPD.

August 1, 2021 Update:

To address the corrective action regarding 115.221(e), the CCCS PC forwarded to the auditor a revised position description relative to the aforementioned VA interviewee. The revised position description clearly addresses requisite provisions of 115.221(e). Since the decision-makers are aware of this development and the duties of the BTC VA, the training component is unnecessary.

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

The BTC PM asserts if requested by the victim, a victim advocate, qualified agency staff member, or qualified community-based organization staff member will accompany and provide emotional support, crisis intervention, information, and referrals during the forensic medical examination process and investigatory interviews.

The one resident who reported a sexual abuse interviewee reports that he did not talk to a VA after reporting a sexual abuse.

As reflected above, the specifics of 115.221(d) are met as requisite protocols are in place. With respect to the fact pattern of the sexual abuse in the interviewee's case, he was not referred for a forensic examination or investigatory interview, nor is there any evidence the interviewee requested the services of a VA.

BTC investigators facilitate administrative sexual abuse/harassment investigations and accordingly, 115.221(f) has been determined to be NA.

In view of the above, the auditor finds BTC compliant with 115.221 based on the corrective action articulated in the narrative for 115.221(e).

Standard 115.222: Policies to ensure referrals of allegations for investigations

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

115.222 (a)

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse? X□ Yes □ No

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

115.222 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? X□ Yes □ No

- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? X□ Yes □ No

- Does the agency document all such referrals? X□ Yes □ No

115.222 (c)

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

115.222 (d)

- Auditor is not required to audit this provision.

115.222 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

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

ing the last 12 months, three administrative sexual abuse or harassment investigations were conducted and completed.

BTC Policy 13.10 entitled Investigations, page 1, section I addresses 115.222(a) addresses 115.222(a).

The CCCS CEO asserts the agency ensures an administrative or criminal investigation is completed for all allegations of sexual abuse or sexual harassment. In regard to administrative investigations, qualified investigators complete all steps of the investigative process [with the exception of physical evidence collection (e.g. DNA)], and the conduct of compelled interviews. A report is then completed. If evidence and the fact pattern suggest criminal standards may have been met, the matter is referred to law enforcement. Again, referral is dependent upon the evidence and circumstances.

The auditor's review of sexual abuse/harassment investigations referenced throughout this report reveals no deviations from 115.222(a).

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

BTC Policy 13.10 entitled Investigations, page 2, section V(B) addresses 115.222(b).

According to the investigative interviewee, agency policy requires that all allegations of sexual abuse or sexual harassment are referred for investigation to BPD unless the allegation does not involve potentially criminal behavior. The interviewee assesses statute and the evidentiary standard to determine whether criminal referral is prudent. Review of documentation and video, etc. is essential in determining whether to refer a matter for criminal investigation. The BPD investigative interviewee asserts he and his peers do facilitate criminal investigations of sexual abuse matters referred to BPD.

The administrative investigation interviewee has not referred any cases to BPD at this point.

The auditor finds relevant policy regarding 115.222(b) is posted on the CCCS website.

Pursuant to the auditor's review, BTC Policy 13.10 entitled Investigations clearly delineates BTC PREA investigator responsibilities in terms of assistance provided to BPD investigators during a criminal investigation.

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

TRAINING AND EDUCATION

Standard 115.231: Employee training

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

115.231 (a)

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? X□ Yes □ No
- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? X□ Yes □ No
- Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment X□ Yes □ No
- Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? X□ Yes □ No
- Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in confinement? X□ Yes □ No
- Does the agency train all employees who may have contact with residents on: The common reactions of sexual abuse and sexual harassment victims? X□ Yes □ No
- Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse? X□ Yes □ No
- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? X□ Yes □ No
- Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? X□ Yes □ No
- Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? X□ Yes □ No

115.231 (b)

- Is such training tailored to the gender of the residents at the employee's facility? X□ Yes □ No
- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? X□ Yes □ No

115.231 (c)

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

- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? X□ Yes □ No

- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? X□ Yes □ No

115.231 (d)

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

Auditor Overall Compliance Determination

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

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

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

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

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

BTC Policy 13.6 entitled Training, pages 1 and 2, section VI(A)(1-10) addresses 115.231(a).

The auditor reviewed the following training resources provided pursuant to the PAQ and finds that the ten topics listed above are included in the PREA training format:

PREA Refresher Course;
PRC Guidance in Cross-Gender and Transgender Pat Searches.

The auditor's review of 2019, 2020, and 2021 quarterly PREA training schedules reveals the course is presented to staff during each quarter. The auditor's review of four 2021 CCCS (BTC) Staff Development and Training Forms reveals affected staff completed and understand the content of the PREA training presented. Staff sign and date the aforementioned form, signifying receipt and understanding of the subject-matter presented.

The auditor's review of three 2018, three 2019, three 2020, and one 2021 employee files reveals affected staff completed and understand the subject-matter of four PREA Orientation courses. Additionally, one

2018, one 2019, and one 2020 PREA annual refresher training (ART) documents reveals substantial compliance with 115.231(a).

The auditor's review of four random staff training files reveals that PREA Orientation was provided prior to contact with residents. This analysis pertains to staff hired during this audit period. The auditor's review of seven of 11 random staff training files further reveals staff completed at least two consecutive PREA ART trainings during 2019 and 2020. of note, 2021 ART training is not yet completed.

The auditor is convinced that staff PREA training is institutionalized. In view of the above, the auditor finds BTC substantially compliant with 115.231(a).

All of the 12 random staff interviewees assert they have received training regarding the 10 topics identified in this provision. Such training was reportedly received during Orientation, PREA ART and minimally, over the course of the last three to five months.

Given the above, the auditor finds BTC substantially compliant with 115.231(a).

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

Pursuant to the policy citation referenced above, all new staff participate in PREA training prior to assignment.

Assessment of relevant training validation is captured in the narrative for 115.231(a).

Pursuant to the PAQ, the Administrator self reports that 33 staff employed by the facility, who may have contact with residents, were trained or retrained in PREA requirements. This constitutes 100% of the staff complement. Staff are expected to review PREA policies periodically between annual PREA ART trainings. As reflected above, all staff receive PREA ART.

In view of the above, the auditor finds BTC exceeds standard provision expectations with respect to 115.231(c) Specifically, the standard provision requires the agency to provide PREA refresher training to staff on a bi-annual basis however, the same is provided to BTC staff on a quarterly basis.

BTC Policy 13.6 entitled Training, page 2, section VI(B) addresses 115.231(c).

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

BTC Policy 13.6 entitled Training, page 2, section VI(C) addresses 115.231(d).

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

Standard 115.232: Volunteer and contractor training

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

115.232 (a)

- Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures? X□ Yes □ No

115.232 (b)

- Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)? X□ Yes □ No

115.232 (c)

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Administrator self reports that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's policies and procedures regarding sexual abuse/harassment prevention, detection, and response. The Administrator further self reports four volunteers provide services to residents at BTC and all have been trained. This equates to 100% of trained volunteers.

The auditor notes that three volunteers have continuously provided services during the last 12 months. He was actually provided contact information relative to these three individuals and accordingly, interviews could only be conducted with them.

BTC Policy 13.6 entitled Training, page 2, section VI(D) addresses 115.232(a).

The auditor's review of the PREA Volunteer and Contractor Training slides reveals substantial compliance with 115.232(a). The same are commensurate with the PREA training necessary for volunteers and contractors. According to the Training Schedule included in the PAQ information, the video "What You Need to Know" is also presented to volunteers and contractors during PREA training. Copies of both company and BTC policy are also distributed to volunteers and contractors wherein "zero tolerance" is clearly articulated. The auditor also reviewed six PREA training signature sheets wherein volunteers/contractors signature attested to review and understanding of the 10 training points referenced in 115.231.

The auditor's review of five 2018 CCCS (BTC) Staff Development and Training Forms regarding In-Service completion of PREA training and a completed document entitled Employee/Volunteer/Contractor Training reveals substantial compliance with 115.232(a). Both forms are signed and dated by the vendor or volunteer. The same documents also apply to another vendor.

The auditor's review of the same kind of 2018 documents (applicable to Orientation) relative to volunteers likewise reveals substantial compliance with 115.232(a). Two 2019 and two 2020 In-Service volunteer files (same documents) and one contractor file likewise substantiate compliance with 115.232(a).

The three volunteer interviewees assert they have received PREA training relative to their responsibilities regarding sexual abuse/harassment prevention, detection, and response. This training was comprised of a video, Power Point Presentation, and lecture. Two interviewees assert they have provided services for approximately five and nine years, respectively, receiving PREA training on an annual basis, with the exception

of 2020. In view of COVID-19 constraints and lack of access to the facility, they did not receive the requisite training during 2020.

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

BTC Policy 13.6 entitled Training, page 2, section VI(E) addresses 115.232(b).

The auditor's review of the Volunteers and Contractors PREA Curriculum reveals substantial compliance with 115.232(b). Additionally, the auditor's review of fifteen 2018, 2019, and 2020 BTC PREA Acknowledgment forms executed by volunteers, contractors, and visitors further substantiates compliance with 115.232(b).

The auditor's review of the BTC Volunteer Handbook reveals two forms (ND DOCR PREA Compliance Acknowledgment and BTC Employee/Volunteer Training) also capture 115.232(b) verbiage.

According to the volunteer interviewees, PREA training addresses zero tolerance, definition(s) of PREA offenses, PREA response, PREA reporting, dynamics of sexual abuse in confinement, warning signs of sexual abuse/harassment, and boundaries between residents and volunteers.

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

BTC Policy 13.6 entitled Training, page 2, section VI(F) addresses 115.232(b).

Relevant 115.232(c) documentation is addressed in the narrative for 115.232(a).

While volunteers have not provided services during the last year in view of COVID-19 constraints, the auditor finds training has been provided during periods of facility access and in accordance with policy and standard.

In view of the above, the auditor finds BTC substantially compliant with 115.232.

Standard 115.233: Resident education

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

115.233 (a)

- During intake, do residents receive information explaining: The agency’s zero-tolerance policy regarding sexual abuse and sexual harassment? X□ Yes □ No
- During intake, do residents receive information explaining: How to report incidents or suspicions of sexual abuse or sexual harassment? X□ Yes □ No
- During intake, do residents receive information explaining: Their rights to be free from sexual abuse and sexual harassment? X□ Yes □ No
- During intake, do residents receive information explaining: Their rights to be free from retaliation for reporting such incidents? X□ Yes □ No

- During intake, do residents receive information regarding agency policies and procedures for responding to such incidents? X□ Yes □ No

115.233 (b)

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

115.233 (c)

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

115.233 (d)

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

115.233 (e)

- In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats? X□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Administrator self reports that residents receive information at time of intake about the zero-tolerance policy, how to report incidents or suspicions of sexual abuse or harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents. The Administrator further self reports 357 residents admitted to BTC during the last 12 months were given this information at intake and this equates to 100%.

CCCS Policy 1.3.5.12 entitled PREA, page 10, section 115.233 (a) and BTC 13.3, page 1, II(a)(1)(a)(i-iii) address 115.233(a).

The intake staff interviewee reports she provides residents with information about the zero-tolerance policy and how to report incidents or suspicions of sexual abuse/harassment. In regard to resident education regarding their rights to be free from sexual abuse/harassment, to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents, the intake staff interviewee reports the same is provided at Orientation, along with the PREA video. The same is generally provided within one week of arrival.

All 11 random resident interviewees report they received either a PREA Handbook, PREA Advisement, and/or the PREA video during intake or Orientation. Maximally, the PREA video and verbal discussion was completed during Orientation within one week of intake. Topics include the resident's right to not be sexually abused/harassed, how to report sexual abuse/harassment, and the resident's right not to be punished for reporting sexual abuse/harassment.

The auditor's review of five executed 2018, five 2019, and five 2020 Receipt of BTC PREA Handbook forms reveals the Handbook was provided at intake. This comprehensive document is commensurate with the requirements of 115.233(a). Additionally, the auditor's review of BTC Resident /Inmate Orientation Training Forms (PREA) (in the same denominations as reflected above) reveals substantial compliance with 115.233(a).

The auditor's review of nine of 10 random resident files reveals residents received requisite documents and training at intake and Orientation. In one case, the resident received Orientation outside the "one week from intake" benchmark as previously described.

Pursuant to the PAQ, the Administrator asserts that the facility provides residents who are transferred from a different community confinement facility with refresher information as referenced above. The Administrator further self reports 77 residents were transferred from another community confinement facility to BTC and all received 115.233(a) PREA training.

BTC 13.3, entitled Intake/Screening, page 2, II(a)(1)(d) addresses 115.233(b).

All 11 random resident interviewees report they were transferred from other facilities.

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

BTC 13.3, entitled Intake/Screening, page 2, II(a)(1)(b) addresses 115.233(c).

A detailed analysis of 115.233(c) requirements is addressed in the narratives for 115.216(a) and (b).

The auditor did review the BTC PREA Handbook which is produced in large print to assist those with low vision. He also reviewed the contract with LanguageLink. The same addresses 240 plus languages and accordingly, non-English speaking residents have ample opportunity to take advantage of PREA education.

The Agency Head designee asserts that, if needed, a Corporate Special Education Teacher could be called on to translate/interpret for developmentally delayed/cognitively impaired resident(s). She is on-call on a 24/7 basis via telephone or in-person.

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

BTC 13.3, entitled Intake/Screening, page 2, II(a)(1)(f) addresses 115.233(d).

The CCCS PC self reports residents do sign and date the Resident PREA Acknowledgment Form, signifying they have been provided 115.233(a) information. This document is also included in the substantiating evidence noted in the narrative for 115.233(a), above.

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

BTC 13.3, entitled Intake/Screening, page 2, II(a)(1)(c) addresses 115.233(e).

Pursuant to the PAQ review process and on-site audit, the auditor reviewed posters available in the male and female units/areas. The posters provide reporting information and reinforce the zero tolerance policy. Additionally, the auditor thoroughly reviewed the BTC PREA Handbook and found the same to be very informative in terms of contact numbers, reporting processes, the grievance process (inclusive of Emergency Grievances), self protection strategies, and PREA definitions.

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

Standard 115.234: Specialized training: Investigations

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

115.234 (a)

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

  X□ Yes □ No □ NA

115.234 (b)

- Does this specialized training include: Techniques for interviewing sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).) X□ Yes □ No □ NA

- Does this specialized training include: Proper use of Miranda and Garrity warnings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).) X□ Yes □ No □ NA

- Does this specialized training include: Sexual abuse evidence collection in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).) X□ Yes □ No □ NA

- Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).)
  X□ Yes □ No □ NA

115.234 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? (N/A if the agency does

not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).)
X□ Yes □ No □ NA

115.234 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Administrator asserts agency policy requires that investigators are trained in conducting sexual abuse investigations in confinement settings.

BTC Policy 13.6 entitled Training, pages 2 and 3, section VI(H)(1) addresses 115.234(a).

The auditor's review of the North Dakota Department of Corrections (ND DOCR) Training Agenda relative to Investigating Sexual Misconduct: Training for Correctional Investigators reveals substantial compliance with 115.234(a).

The auditor's review of six ND DOCR PREA Investigator Training and Investigating Sexual Abuse in a Correctional Setting certificates reveals six BTC staff completed requisite training. One of the trained investigators is the PCM. Additionally, the Administrator has completed the NIC course entitled PREA: Investigating Sexual Abuse in a Confinement Setting.

While the Administrator is designated as a sexual abuse investigator and he is actively involved in most, if not all, sexual abuse/harassment investigations, the auditor finds no evidence he facilitated investigations with respect to any mentioned throughout this report. He completed requisite sexual abuse/harassment investigator training on April 5, 2021. He completed the National Institute of Corrections (NIC) on-line modules as evidenced by relevant Staff Development and Training Record Forms.

According to the investigative staff interviewee, he did receive specialized training regarding the conduct of sexual abuse investigations in confinement settings. One training was presented by ND DOCR while another 16 hour training was provided by BPD. Finally, he has completed the on-line NIC course as previously mentioned.

The BPD investigative interviewee asserts he completed sexual abuse investigative training at the Academy and pursuant to specialized training. Generally, the training addressed sexual abuse investigative techniques in the community, etc. The same was comprised of classroom lecture and the same was interactive.

BTC Policy 13.6 entitled Training, page 3, section VI(H)(2) addresses 115.234(b).

The auditor's review of the syllabus for the North Dakota PREA Investigator Training reveals the same includes techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or criminal prosecution. The auditor also reviewed the course syllabus for the NIC course entitled PREA: Investigating Sexual Abuse in a Confinement Setting and the same clearly meets the requirements of 115.234(b).

According to the investigative staff interviewee, the specialized training he received addressed techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral.

Pursuant to the PAQ, the Administrator self reports the agency maintains documentation showing that investigators have completed the required training.

The Administrator further self reports five sexual abuse investigators are currently certified at BTC.

BTC Policy 13.6 entitled Training, page 3, section VI(H)(3) addresses 115.234(c).

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

Standard 115.235: Specialized training: Medical and mental health care

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

115.235 (a)

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

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

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

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

115.235 (b)

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

  □ Yes □ No X□ NA

115.235 (c)

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

115.235 (d)

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

- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.) □ Yes □ No X□ NA

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Administrator self reports the agency has a policy related to the training of medical and mental health practitioners who work regularly in its facilities. The CCCS PC reports medical and mental health staff are not employed at BTC. Of note, the auditor confirmed the same pursuant to observation.

In view of the above, the auditor finds that 115.235 is not applicable to BTC. However, since there are no deviations from standard, the auditor finds BTC substantially compliant with 115.235.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.241: Screening for risk of victimization and abusiveness

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

115.241 (a)

- Are all residents assessed during an intake screening for their risk of being sexually abused by other residents or sexually abusive toward other residents? X□ Yes □ No

- Are all residents assessed upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents? X□ Yes □ No

115.241 (b)

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

115.241 (c)

- Are all PREA screening assessments conducted using an objective screening instrument? X□ Yes □ No

115.241 (d)

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has a mental, physical, or developmental disability? X□ Yes □ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The age of the resident? X□ Yes □ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The physical build of the resident? X□ Yes □ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously been incarcerated? X□ Yes □ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident's criminal history is exclusively nonviolent? X□ Yes □ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has prior convictions for sex offenses against an adult or child? X□ Yes □ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming (the facility affirmatively asks the resident about his/her sexual orientation and gender identity AND makes a subjective determination based on the screener's perception whether the resident is gender non-conforming or otherwise may be perceived to be LGBTI)? X□ Yes □ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously experienced sexual victimization? X□ Yes □ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The resident's own perception of vulnerability? X□ Yes □ No

115.241 (e)

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior acts of sexual abuse? X□ Yes □ No

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior convictions for violent offenses? X□ Yes □ No

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: history of prior institutional violence or sexual abuse? X□ Yes □ No

115.241 (f)

- Within a set time period not more than 30 days from the resident's arrival at the facility, does the facility reassess the resident's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening? X□ Yes □ No

115.241 (g)

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

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

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

- Does the facility reassess a resident's risk level when warranted due to a: Receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness? X□ Yes □ No

115.241 (h)

- Is it the case that residents are not ever disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section? X□ Yes □ No

115.241 (i)

- Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents? X□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

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

BTC Policy 14.3 entitled Intake/Screening, pages 3 and 4, section II(B) addresses 115.241(a).

According to the two staff who screen for risk of victimization and abusiveness interviewees, one screens residents upon admission to the facility or transfer from another facility for risk of sexual victimization or sexual abusiveness toward other residents while the other employee facilitates 30-day reassessments. A PREA Assessment Tool is used and the same is administered at Intake.

Nine of 11 random resident interviewees stated upon arrival at the facility, they were asked questions like whether they had been in jail or prison before, whether they had ever been sexually abused, whether they identify as being gay, lesbian, or bisexual, and whether they think they might be in danger of sexual abuse at the facility. According to these respondents, the questions, along with many others, were asked during the intake process.

The auditor did review the file of both residents who assert they had not been screened or had not been asked all requisite questions as reflected above. Pursuant to review, the initial screenings were conducted in a timely and comprehensive manner.

The auditor finds substantial compliance with both policy and 115.241(a).

Pursuant to the PAQ, the Administrator self reports the policy requires that residents be screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of intake. The Administrator further self reports that during the last 12 months, 357 residents entered the facility (either through intake or transfer) whose length of stay in the facility was for 72 hours or more who were screened for risk of sexual victimization or risk of sexually abusing other residents, within 72 hours of their entry into the facility. This equates to 100% of requisite screenings.

The policy referenced in the narrative for 115.241(a) is also applicable to 115.241(b).

A re-capitulation of on-site resident file reviews is noted in the narrative for 115.241(a).

According to the staff who performs initial screening for risk of victimization and abusiveness interviewee, residents are screened for the same within 72 hours of their Intake. According to the initial screening interviewee, residents are actually screened at intake or within 24 hours of arrival at the facility.

Pursuant to the PAQ, the Administrator self reports that such assessments are conducted using an objective screening instrument.

BTC Policy 13.3 entitled Intake/Screening, page 3, section II(B)(1) addresses 115.241(c).

As reflected in the policy cited above, the BTC PREA Assessment addresses all of the objective criteria identified in 115.241(d).

The auditor reviewed the objective BTC Initial Assessment/Re-Assessment Prison Rape Elimination Act (PREA) screening tool and found the same to minimally address the following provision requirements:

Whether the resident has a
mental, physical, or developmental
disability;
The age of the resident;
The physical build of the resident;
Whether the resident has
previously been incarcerated;
Whether the resident's criminal
history is exclusively nonviolent;
Whether the resident has prior
convictions for sex offenses against
an adult or child;
Whether the resident is or is
perceived to be gay, lesbian, bisexual,
transgender, intersex, or gender
nonconforming;
Whether the resident has
previously experienced sexual

victimization; and
The resident's own perception of
vulnerability.

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

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

The auditor's review of the BTC Initial Assessment/Re-Assessment PREA screening tool as reflected above confirms the information reflected in this provision.

The auditor's review of five 2018, five 2019, and five 2020 BTC Initial Assessments reveals substantial compliance with 115.241(d). All initial assessments were completed on the date of arrival at BTC and all appear to be comprehensive.

When questioned as to what the initial risk screening entails, both staff who perform risk screening for risk of victimization and abusiveness interviewees articulated issues including: Have you ever been forced into sex or have you forced someone else into sex either in custody or in the community?; Have you ever been sexually abused?; Do you self identify as LGBTI?; Height; Weight; Prior criminal history; Mental history; History of violence; and physical build.

When questioned as to the process for conducting the initial screening, the initial screening interviewee related the assessment is facilitated in a private room near the RA Office behind a closed door, utilizing the PREA Assessment Tool. There is a window in the room and the RA and the resident are present during the screening. The screener reads the questions to the resident, documenting responses. Of note, the interviewee reviews a pre-admission packet prior to facilitation of the screening, using the same to clarify any disputes in terms of responses. Pursuant to the screening process, a determination is made as to whether the resident is a victim, non-victim, aggressor, or non-aggressor.

The reassessment process is conducted in identical fashion with the exception that the screening occurs in the case manager's office. Both screenings are conducted in a one-on-one setting.

Pursuant to the PAQ, the Administrator self reports the intake screening tool considers prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the agency, in assessing residents for risk of being sexually abusive. The auditor validates the same pursuant to the narrative articulated at 115.241(d).

BTC Policy 13.3 entitled Intake/Screening, page 4, section II(B)(2) addresses 115.241(e).

Pursuant to the PAQ, the Administrator self reports the policy requires that the facility reassess each resident's risk of victimization or abusiveness within a set time period, not to exceed 30 days after the resident's arrival at the facility, based upon any additional, relevant information received by the facility since the intake screening. The Administrator further self reports that during the last 12 months, 291 residents entering the facility (either through intake or transfer) were reassessed for their risk of sexual victimization or being sexually abusive, within 30 days after their arrival at the facility based upon any additional relevant information received since intake. Sixty-six residents did not remain at BTC for 30 days or more.

BTC Policy 13.3 entitled Intake/Screening, pages 4 and 5, section II(B)(3) addresses 115.241(f).

The staff who performs screening for risk of victimization and abusiveness interviewee (reassessments) reports PREA reassessments are completed within 30 days of arrival at BTC. He/she tracks arrival dates, ensuring completion of the reassessment between 21 and 30 days from arrival. Tacking is accomplished via a checklist.

Two of 11 random resident interviewees report they either hadn't been reassessed or they didn't know. The auditor's review of six applicable reassessments (only for those residents confined at BTC for 30-days from intake) reveals the reassessments were both timely and comprehensive. Two interviewees had not been confined at BTC for 30 days from intake.

The auditor's pre-audit review of the 15 files mentioned in the narrative for 115.241(d) reveals that reassessments were facilitated in a timely and comprehensive manner pursuant to 115.241(f). The auditor's on-site review of eight random resident files (relevant to residents who had been at BTC for at least 30-days from intake) reveals each reassessment was conducted in both a timely and comprehensive manner.

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

BTC Policy 14.3 entitled Intake/Screening, page 5, section II(B)(4) addresses 115.241(g).

The staff who performs screening for risk of victimization and abusiveness interviewee (reassessments) reports resident's risk levels are reassessed as needed due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness. The case manager supervisor triggers reassessment(s) pursuant to 115.241(g). In the case of a sexual abuse incident occurring at BTC, both the victim and the perpetrator are reassessed. The interviewee was not aware of any such situations relevant to his/her caseload.

Of note, with respect to the 2021 sexual abuse allegation, the perpetrator was quickly removed from the facility and the victim was also released. Accordingly, reassessments were not facilitated in either case.

The CCCS PC self reports during the last 24 months, zero residents were reassessed pursuant to 115.241(g) circumstances.

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

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

BTC Policy 13.3 entitled Intake/Screening, page 5, section II(B)(6) addresses 115.241(h).

The above is generally addressed in the BTC PREA Assessment Disclaimer which is completed by the resident and a staff member prior to implementation of the screening tool during initial assessment or reassessment. This Disclaimer Form must be signed by the resident every time a reassessment is conducted. The auditor's review of the aforementioned assessments and reassessments reveals substantial compliance with 115.241(h).

When questioned as to whether residents are disciplined in any way for refusing to respond to (or for not disclosing complete information related to):

Whether the resident has a mental, physical, or development disability;
Whether the resident is or is perceived to be LGBTI;
Whether the resident has previously experienced sexual victimization; or
The resident's own perception of vulnerability.
both staff who perform screening for risk of victimization and abusiveness responded in the negative. Both staff advised the Disclaimer tells them they will not be disciplined.

BTC Policy 13.3 entitled Intake/Screening, page 5, section II(B)(7) addresses 115.241(i).

According to the PREA Coordinator, the agency has outlined who should have access to a resident's risk assessment within the facility in order to protect sensitive information from exploitation. According to the PREA Coordinator, access is limited to the screener, Administrator, PCM, case managers, and case manager supervisor.

According to the staff who perform screening for risk of victimization and abusiveness, distribution of screening information to the Administrator, PCM, case managers, and case manager supervisor is appropriate. The PCM signs and then files the screening tools in her office. The information is stored in double locked fashion (in a safe and then the door to the PCM's office is secured). The auditor witnessed the same during the facility tour and subsequent interaction with the PCM.

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

Standard 115.242: Use of screening information

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

115.242 (a)

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Housing Assignments? X□ Yes □ No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Bed assignments? X□ Yes □ No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Work Assignments? X□ Yes □ No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Education Assignments? X□ Yes □ No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Program Assignments? X□ Yes □ No

115.242 (b)

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

115.242 (c)

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)? X□ Yes □ No

- When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems? X□ Yes □ No

115.242 (d)

- Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments? X□ Yes □ No

115.242 (e)

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

115.242 (f)

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

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

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Administrator self reports the facility uses information from the risk screening to inform housing, bed, work, education, and program assignments with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive.

BTC Policy 13.3 entitled Intake Screening, pages 5 and 6, section II(B)(9)(b) addresses 115.242(a).

At BTC, a system of housing is used to ensure that Known Victims/Potential Victims (KVs/PVs) and Known Aggressors/Potential Aggressors (KAs/PAs) are not housed in the same room. During the on-site review, the auditor randomly reviewed documents and observed no deviations from the stated practice.

The auditor's review of five 2019, 2020, and 2021 BTC Daily Count Sheets reveals substantial compliance with 115.242(a). The Count Sheets reflect the rooms wherein KVs PVs, KAs, and PAs are housed. The auditor found no discrepancies regarding any of the housing assignments wherein victims and abusers are housed together.

According to the BTC PM, housing assignments are the primary use for information gleaned during risk screening. Specifically, KAs/PAs are not housed in the same room with KVs/PVs. They are generally separated by both room and building. KAs/PAs are housed in the back building while KVs/PVs are generally housed in the front building. Those residents classified as "unrestriceted" are housed with either of the other classifications. With respect to programming, there is generally no separation as staff supervise the same. There is likewise no separation for community work assignments however, periodic staff checks are employed.

The two staff who perform risk screening for victimization and abusiveness report housing assignments are primarily based on the information gleaned from the risk assessment conducted during intake. The shift supervisor makes room assignments. Both interviewees corroborate the PM's statement.

Pursuant to the PAQ, the Administrator self reports the facility makes individualized determinations about how to ensure the safety of each resident.

BTC Policy 13.3 entitled Intake/Screening, page 6, section II(B)(9)(c) addresses 115.242(b).

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

BTC Policy 13.3 entitled Intake/Screening, page 6, section II(B)(9)(d) addresses 115.242(c).

According to the BTC PM, transgender/intersex residents may be housed in single rooms, dependent upon the circumstances however, such residents are not housed in a specific wing or room.

Staff do consider whether the placement will ensure the resident's health and safety, as well as, whether the placement will present management or security problems.

The transgender/intersex inmate interviewee reports staff have asked questions about his safety on a random basis. Additionally, the interviewee reports he has not been placed in a housing area designated only for transgender or intersex residents and has not been strip-searched for the sole purpose of determining genitalia.

BTC Policy 13.3 entitled Intake/Screening, page 5, section II(B)(9)(f) addresses 115.242(d).

The BTC PM asserts a transgender/intersex resident's own views with respect to his/her own safety are given serious consideration.

According to the staff who perform screening for risk of victimization and abusiveness interviewees, a transgender/intersex resident's views of his or her own safety are given serious consideration in placement and programming assignments. The safety perception is addressed in the screening tool.

BTC Policy 14.2 entitled LGBTI Gender Identity and Gender Expression, Housing, Programs, and Searches, page 4, section IV(B)(4) addresses 115.242(e).

According to the BTC PM, transgender/intersex resident(s) are given the opportunity to shower separately from other residents. Specifically, they can request separate showering and the same is documented. The Administrator and/or PM are the approving authorities. Such showers are provided in the 1st Floor Administration bathroom.

The two staff who perform screening for risk of victimization and abusiveness interviewees confirm the BTC PM's statement.

The transgender/intersex interviewee confirms he is able to shower separate from other residents, if requested.

BTC Policy 13.3 entitled Intake/Screening, page 7, section II(B)(9)(j) addresses 115.242(f).

According to the BTC PM, the facility is not subject to a consent decree, legal judgment requiring that it establish a dedicated facility, unit, or wing for LGBTI residents. There are no dedicated wings.

To ensure LGBTI residents are not housed in specific designated areas, the count sheet is reviewed daily for quality control and standard compliance.

The two LGBTI resident interviewees report they have not been placed in a housing area only for LGBTI residents.

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

REPORTING

Standard 115.251: Resident reporting

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

115.251 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? X□ Yes □ No
- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? X□ Yes □ No
- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? X□ Yes □ No

115.251 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? X□ Yes □ No
- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? X□ Yes □ No
- Does that private entity or office allow the resident to remain anonymous upon request? X□ Yes □ No

115.251 (c)

- Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties? X□ Yes □ No
- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? X□ Yes □ No

115.251 (d)

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Administrator self reports the agency has established procedures allowing for multiple internal ways for residents to report privately to agency officials about:

Sexual abuse or sexual harassment;
Retaliation by other residents or staff for reporting sexual abuse and sexual harassment; and
Staff neglect or violation of responsibilities that may have contributed to such incidents.

BTC Policy 13.4 entitled Reporting Sexual Abuse and Sexual Harassment, pages 1 and 2, section II(a)(i-v) addresses 115.251(a).

Pages 4, 5, and 6 of the BTC PREA Handbook also address 115.251(a). Relevant provisions in the Handbook are as follows:

How to Report an Incident of Sexual Assault

It is important that you tell a staff member if you have been sexually assaulted. You can tell your case manager, counselor, security staff, the Administrator or any other staff member you trust. BTC staff members are instructed to keep the reported information confidential and only discuss it with the appropriate officials on a "need to know" basis.

You may also report abuse or harassment to a public or private entity or office who will be able to receive and immediately forward resident reports of sexual abuse and sexual harassment to BTC officials, allowing you to remain anonymous upon request. You may call BPD at 223-1212, as well as the Abused Adult Resource Center at 1-866-341-7009. Your communication with those facilities will be completely confidential.

Third Party Reporting
The following people may assist you in filing requests for administrative remedies relating to allegations of sexual abuse, and to file on behalf of yourself: fellow resident, staff member, family member, attorneys and outside advocates.

Other Ways to Report
Write directly to the Program Chief of Security, Program Administrator, PREA Coordinator or North Dakota Department of Corrections and Rehabilitation. You can send the Chief of Security or Program Administrator a Request to Speak to Staff form or a letter reporting the sexual misconduct.

If a third party files a request on your behalf, BTC may require, as a condition of processing the request, that the alleged victim agree to have the request filed on her or his behalf and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process. Should the alleged victim decline to have the request filed on his or her behalf, BTC staff will document the residents' decision.

Emergency Grievance:
BTC has established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse. (2) After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, BTC will 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, and will provide an initial response within 48 hours, and will issue a final agency decision within 5 calendar days. The initial response and final agency decision will document BTC's determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance.

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

Contact information for AARC and RAINN is posted next to telephones. Reports to these agencies allow the resident to remain anonymous upon request.

The auditor notes that contact with RAINN does not meet the intent and letter of 115.251(a) as RAINN staff do not forward the report to facility officials. The auditor learned of this information during a previous audit.

While the auditor finds BTC substantially compliant with 115.251(a) and (b), he is directing the BTC PM to notify all BTC staff and residents that RAINN is not an acceptable 115.251(b) reporting source. Additionally, amendment of the corresponding BTC PREA Handbook, policy, poster(s), and training Power Point Presentation must be completed to ensure all future residents and staff are properly informed of 115.251(b) reporting options.

The BTC PM will provide to the auditor a copy of the amended policy, the BTC PREA Handbook, poster(s), and the BTC Power Point presentation, as well as, training documentation certifying all staff have been properly trained regarding the aforementioned changes. An email as to the completion date of resident notification of the changes will suffice.

The above actions must be completed on or before December 13, 2021.

All twelve random staff interviewees identified at least one method which residents can use to report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, or staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment. Reporting methods mentioned were as follows; report to any staff member, submit an Emergency Grievance, contact BPD, third-party report, contact RAINN, submit a kite, and contact the Administrator and Executive Staff via the resident's cell phone while out in the community.

All 11 random resident interviewees were able to identify at least two methods of reporting the aforementioned sexual abuse and sexual harassment allegations. Methods of reporting included verbal reports to staff, reporting to family or community resource, submission of a kite, submission of an Emergency Grievance, third-person report, contact RAINN, and contact BPD.

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

Relevant policy and PREA Handbook citations (inclusive of specific instructions in this regard) are reflected in the narrative for 115.251(a) above.

The auditor's review of a signed MOU between BTC and BPD reveals substantial compliance with 115.251(b).

According to the BTC PM, residents can contact BPD to report sexual abuse or harassment to a public or private entity or office that is not part of the agency. These procedures enable receipt and immediate transmission of resident reports of sexual abuse and sexual harassment to agency officials that allow the resident to remain anonymous upon request.

Ten of 11 random resident interviewees assert a report can be made without providing their name.

Pursuant to the PAQ, the Administrator self reports the agency has a policy mandating that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties. Staff are required to document verbal reports and the same is effected immediately.

CCCS Policy 1.3.5.12 entitled Prison Rape Elimination Act, page 14, section 115.251(c) addresses 115.251(c).

All 12 random staff interviewees report that residents can make verbal reports and they would immediately document the same subsequent to receipt.

All 11 random resident interviewees assert they can make verbal reports of sexual abuse or sexual harassment either in person or in writing. Additionally, ten of 11 interviewees assert someone else may make the report for them so they do not have to be named.

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

Policy provisions are cited in the narrative for 115.251(a). The actual direction is also cited in the same.

All 12 random staff interviewees were aware of multiple methods for reporting sexual abuse and sexual harassment of residents. Some of the methods cited were as follows; verbal report to supervisor/Administrator/BTC PM, COS, telephone call to same individuals during regular work hours, telephone call to cell phones during non-regular business hours (cell phone numbers are listed in the RA Office), send e-mail to the aforementioned staff, send written memorandum to the aforementioned staff, drop a note in the Emergency Grievance box, contact AARC and/or RAINN, and contact BPD. The auditor did observe a document maintained in the RA Office wherein company cell phone numbers are listed.

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

Standard 115.252: Exhaustion of administrative remedies

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

115.252 (a)

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

115.252 (b)

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

- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.) X□ Yes □ No □ NA

115.252 (c)

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) X□ Yes □ No □ NA

- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) X□ Yes □ No □ NA

115.252 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day

time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) X□ Yes □ No □ NA

- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time (the maximum allowable extension of time to respond is 70 days per 115.252(d)(3)) , does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) X□ Yes □ No □ NA

- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) X□ Yes □ No □ NA

115.252 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)
X□ Yes □ No □ NA

- Are those third parties also permitted to file such requests on behalf of residents? (If a third-party files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.) X□ Yes □ No □ NA

- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)
X□ Yes □ No □ NA

115.252 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) X□ Yes □ No □ NA

- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.).
X□ Yes □ No □ NA

- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) X□ Yes □ No □ NA

- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)
X□ Yes □ No □ NA

- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) X□ Yes □ No □ NA

- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) X□ Yes □ No □ NA

- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) X□ Yes □ No □ NA

115.252 (g)

- If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.) X□ Yes □ No □ NA

Auditor Overall Compliance Determination

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

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

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

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

BTC Policy 13.4 entitled Reporting Sexual Abuse and Sexual Harassment, pages 3 and 4, section II(a)(xiii)(1-6) addresses 115.252(a).

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

BTC Policy 14.4 entitled Reporting Sexual Abuse and Sexual Harassment, page 3, section II(a)(xiii)(1-4) addresses 115.252(b).

The auditor's review of the BTC PREA Handbook reveals this information is clearly articulated on page 5 of the same.

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

BTC Policy 13.4 entitled Reporting Sexual Abuse and Sexual Harassment, page 4, section II(a)(xiii)(5)(e) addresses 115.252(c).

Page 5 of the BTC PREA Handbook, section entitled Grievance Procedure (b) and (b)(2) also addresses this provision.

Pursuant to the PAQ, the Administrator self reports agency policy and procedure requires that a decision on the merits of any grievance or portion of a grievance alleging sexual abuse be made within 90 days of the filing of a grievance. The Administrator further self reports during the last 12 months, zero grievances have been filed regarding sexual abuse against residents. The agency always notifies the resident in writing when the agency files for an extension, including notice of the date by which a decision will be made.

BTC Policy 13.4 entitled Reporting Sexual Abuse and Sexual Harassment, page 4, section II(a)(xiii)(6)(a-d) addresses 115.252(d).

The resident who reported a sexual abuse interviewee reports he received a written response the day following submission of his grievance regarding the decision. He is aware facility staff are required to advise of any decision within 90 days of submission of the grievance. As mentioned above, an extension for grievance response was not necessary.

Pursuant to the PAQ, the Administrator self reports agency policy and procedure permits third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, to assist residents in filing requests for administrative remedy relative to allegations of sexual abuse and to file such requests on behalf of residents. The Administrator further self reports agency policy and procedure requires that if the resident declines to have third-party assistance in filing a grievance alleging sexual abuse, the agency documents the resident's decision to decline.

BTC Policy 13.4 entitled Reporting Sexual Abuse and Sexual Harassment, page 7, section II(d)(ii and iii) addresses 115.252(e). This policy stipulates 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, such as filing grievances relating to allegations of sexual abuse and sexual harassment, and will also be permitted to file such requests on behalf of residents.

If a third party files a grievance on behalf of the resident, the facility may require, as a condition of processing the request, that the alleged victim agrees to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process. Should the alleged victim decline to have the request filed on his or her behalf, the center shall document the resident’s decision.

Pursuant to the PAQ, the Administrator self reports the agency has a policy and established procedures for filing an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse. The Administrator further self reports agency policy and procedure for emergency grievances alleging substantial risk of imminent sexual abuse requires an initial response within 48 hours.

One emergency grievance (did not allege imminent sexual abuse but, rather sexual abuse that had already occurred) was filed during the last 12 months. As discussed in the narrative for 115.252(e), the victim reports a response was completed the day following emergency grievance submission.

The Administrator asserts agency policy and procedure for emergency grievances alleging substantial risk of imminent sexual abuse requires that a final agency decision be issued within five days of submission. As reflected above, this singular grievance was addressed within one day of submission.

BTC Policy 13.4 entitled Reporting Sexual Abuse and Sexual Harassment, page 3, section II(a)(xiii)(5)(a and b) addresses 115.252(f).

While the above grievance submission does not meet the definition of emergency grievance, the auditor includes the same in the report to accentuate the zeal and deliberate intent with which BTC staff address the grievance portion of resident safety at BTC. The auditor finds BTC staff exceeded expectations with respect to the handling of this matter.

Pursuant to the PAQ, the Administrator self reports the agency has a written policy that limits its ability to discipline a resident for filing a grievance alleging sexual abuse to occasions where the agency demonstrates that the resident filed the grievance in bad faith. The Administrator further self reports in the last 12 months, zero resident grievances alleging sexual abuse resulted in disciplinary action by the agency against the resident for having filed the grievance in bad faith.

BTC Policy 13.4 entitled Reporting Sexual Assault and Sexual Harassment, page 3, section II(a)(xiii)(5)(c) addresses 115.252(g).

In view of the above, the auditor finds BTC exceeds standard expectations with respect to 115.252.

Standard 115.253: Resident access to outside confidential support services

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

115.253 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? X□ Yes □ No

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

115.253 (b)

- Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws? X□ Yes □ No

115.253 (c)

- Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse? X□ Yes □ No

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Administrator self reports the facility provides residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers (including toll-free hotline numbers where available) for local, state, or national victim advocacy or rape crisis organizations. The Administrator further self reports the facility provides residents with access to outside victim advocates for emotional support services related to sexual abuse by enabling reasonable communication between residents and these organizations in as confidential a manner as possible.

BTC Policy 13.5 entitled Medical and Mental Health, page 2, section II(B)(1) addresses 115.253(a).

The auditor's review of an MOU with AARC reveals substantial compliance with 115.253(a).

Pursuant to the auditor's review of the Resident PREA Handbook, pages 4, section entitled Resident Access to Outside Confidential Support Services, and 7 address 115.253(a). The aforementioned citations direct the reader to the posters hung throughout the facility. The auditor has determined ample information is provided to residents to address this provision.

Ten of 11 random resident interviewees report they are aware services are available outside of the facility for dealing with sexual abuse, if needed. Five of 11 reported they are aware of the kind of services, citing AARC, RAINN, BPD, and counseling. The remaining interviewees assert they are not aware of the available services.

Additionally, eight interviewees assert they are aware that addresses and telephone numbers for the services are available in the BTC PREA Handbook, posted on bulletin boards, and noted on posters. Eight of 11 interviewees also stated the numbers are toll-free. Nine interviewees state contact can be made with these services anytime.

The resident who reported a sexual abuse interviewee states such outside services are available, if needed by sexual abuse victims, and relevant information is available in the BTC PREA Handbook. He did not access any such services following his sexual abuse experience. Contact can be made anytime.

The interviewee further states he can communicate with staff from the services in a confidential manner however, his conversation could be shared with or listened to by someone else if he divulges information requiring law enforcement intervention.

The auditor noted ample posters bearing contact information for AARC. As reflected above, most random staff interviewees are aware requisite information can be gleaned from posters, the BTC PREA Handbook, and bulletin boards.

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

BTC Policy 14.5 entitled Medical and Mental Health, page 2, section II(B)(2) addresses 115.253(b). The auditor's review of page 7 of the BTC PREA Handbook, section entitled Counseling Programs for Victims of Sexual Assault also addresses 115.253(b).

While nine of 11 random resident interviewees believe that what is said to staff from outside support services in response to a sexual abuse incident remains private, three also state information may be shared with or listened to by other parties based on mandatory reporting for law enforcement use or somebody is in danger.

In view of the above, the auditor finds BTC residents have ample resources to remain informed regarding the nuances of 115.253(b).

Pursuant to the PAQ, the Administrator self reports the facility does maintain memoranda of understanding (MOUs) with community service providers that are able to provide residents with emotional support services related to sexual abuse. The 2018-2020 MOUs between BTC and AARC are referenced in the narrative for 115.253(a).

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

Standard 115.254: Third-party reporting

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

115.254 (a)

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? X□ Yes □ No

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Administrator self reports the facility provides a method to receive third-party reports of resident sexual abuse or sexual harassment. The CCCS third party reporting form is located on all floors and the www.cccscorp.com website is clearly available to all. All reports go directly to the PREA Coordinator who, in turn, distributes the same to each facility. All phone calls will be taken by the Administrator or PM at the facility. If the PM is contacted, she will immediately contact the Administrator. Emails are another source of receiving third party reports and they will be brought to the Administrator immediately. The Administrator further self reports the facility publicly distributes information on how to report residential sexual abuse or sexual harassment on behalf of residents.

BTC Policy 13.4 entitled Reporting Sexual Abuse and Sexual Harassment, page 7, section II(d)(i) addresses 115.254(a).

The auditor's review of the BTC Third Party Reporting Form reveals the same provides specific directions for making a report in terms of the information to be reported. There is also a provision on the form wherein the third party reporter can enter their telephone number. The CCCS PC's address, e-mail address, and telephonic contact number are also reflected on the form.

The Administrator self reports zero third-party reports have been received during the audit period.

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

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.261: Staff and agency reporting duties

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

115.261 (a)

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? X□ Yes □ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? X□ Yes □ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? X□ Yes □ No

115.261 (b)

- Apart from reporting to designated supervisors or officials, do staff always refrain from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions? X□ Yes □ No

115.261 (c)

- Unless otherwise precluded by Federal, State, or local law, are medical and mental health practitioners required to report sexual abuse pursuant to paragraph (a) of this section? X□ Yes □ No

- Are medical and mental health practitioners required to inform residents of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services? X□ Yes □ No

115.261 (d)

- If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, does the agency report the allegation to the designated State or local services agency under applicable mandatory reporting laws? X□ Yes □ No

115.261 (e)

- Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators? X□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Administrator self reports the agency requires 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;
Any retaliation against residents or staff who reported such an incident;
Any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

BTC Policy 13.4 entitled Reporting Sexual Abuse and Sexual Harassment, page 5, section II(c)(i) addresses 115.261(a).

All 12 random staff interviewees stated the agency does require all staff to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. All 12 random staff interviewees assert that immediate reporting, minimally, to their supervisor was required pursuant to policy. Random staff interviewees also stated reports can be forwarded to the Administrator, BTC PM, cos, and at least one investigator.

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

BTC Policy 13.4 entitled Reporting Sexual Abuse and Sexual Harassment, pages 5 and 6, section II(c)(ii and iii) addresses 115.261(b).

BTC Policy 13.4 entitled Reporting Sexual Assault and Sexual Harassment, page 6, section II(c)(v) addresses 115.261(c).

The CCCS PC asserts zero medical or mental health staff are employed at BTC. During the on-site audit, the auditor validated the same.

BTC Policy 13.4 entitled Reporting Sexual Abuse and Sexual Harassment, page 6, section II(c)(iv) addresses 115.261(d).

According to the Administrator and BTC PM, residents under the age of 18 are not accepted at BTC. In terms of vulnerable adults, CCCS policy allows the Administrator to make a determination regarding acceptance of residents. If the potential resident cannot work, comprehend groups/regulations/perform basic functions, acceptance could be declined. A vulnerable adult population is non-existent or minimal, at best, at BTC. If reporting requirements were invoked, the incident would be reported and future action would be coordinated with ND DOCR.

It is noted that the contract between BTC and ND DOCR also allows for acceptance or denial of residents.

BTC Policy 13.4 entitled Reporting Sexual Assault and Sexual Harassment, page 2, section II(a)(vi) addresses 115.261(e).

According to the Administrator, all allegations of sexual abuse and sexual harassment (including those from third-party and anonymous sources) are reported directly to him and he alerts facility investigators regarding the investigative assignment.

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

Standard 115.262: Agency protection duties

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

115.262 (a)

- When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident? X□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Administrator self reports when the facility learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident (i.e. it takes some action to assess and implement appropriate protective measures without unreasonable delay). The Administrator further self reports that during the last 12 months, zero incidents have been reported wherein the agency determined a resident was subject to substantial risk of imminent sexual abuse. The Administrator asserts action is taken immediately to address imminent sexual abuse.

BTC Policy 13.4 entitled Reporting Sexual Abuse and Sexual Harassment, page 2, section II(a)(vii) addresses 115.262(a).

According to the Agency Head designee, when staff learn that a resident is subject to a substantial risk of imminent sexual abuse, the offender may ultimately be removed from facility, dependent upon the circumstances. The Administrator would also be contacted with a recommendation that the offender be moved to another room or unit.

When it is learned that a resident is subject to a substantial risk of imminent sexual abuse, the Administrator advises that staff would communicate with the potential victim and remove him/her from the danger zone. Additionally, safety rounds may be increased as a remedial measure if, for some reason, the potential victim was placed in another area of the facility. Additionally, the potential victim may be moved to another facility dependent upon the circumstances and with the approval of the on-call probation officer.

All 12 random staff interviewees assert that action would be implemented immediately. Responses include removing the potential victim from the situation by placing them in another area with staff supervision. Proper reporting and documentation would likewise be completed. Additionally, dependent upon the information known at the time, the potential perpetrator might be moved and placed under constant surveillance.

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

Standard 115.263: Reporting to other confinement facilities

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

115.263 (a)

- Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred? X□ Yes □ No

115.263 (b)

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

115.263 (c)

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

115.263 (d)

- Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards? X□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

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

BTC Policy 13.4 entitled Reporting Sexual Abuse and Sexual Harassment, page 7, section II(c)(x) addresses 115.263(a).

The auditor did not find any instances wherein an alleged sexual abuse occurred while a resident was confined at another facility and he/she subsequently reported the same to BTC staff.

Pursuant to the PAQ, the Administrator self reports agency policy requires that the facility head provide such notification as soon as possible, but no later than 72 hours after receiving the allegation.

Of note, policy requires reporting by the BTC Administrator to the head of the facility at which the sexual abuse allegedly occurred, within 24 hours.

Pursuant to the PAQ, the Administrator self reports the facility documents that it has provided such notification within 72 hours of receiving the same.

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

The policy citation, as reflected in the narrative for 115.263(a) is also applicable to 115.263(d).

The auditor's review of two sexual abuse investigations completed during the last 24 months reveals substantial compliance with 115.263(d) as once advised of allegations by administrators at ND DOCR facilities, investigations were promptly initiated and concluded regarding allegations of sexual abuse arising at BTC.

According to the Agency Head interviewee, the Administrator or designee at the receiving facility is the designated point of contact to receive such allegations. When such allegations are received, the incident is to be investigated immediately. If evidence is found, a message is relayed to the facility head who sent the message, advising of the outcome.

According to the Administrator, an investigation is immediately initiated in accordance with standards 115.221, 115.222, and 115.271. Relevant reporting requirements regarding ND DOCR are accomplished and all criminal investigative considerations are addressed. The Administrator would contact the reporting Warden or Administrator and advise of the status of the investigation. The Administrator also advises there are examples of another facility or agency reporting such allegations.

The auditor notes that those allegations and accompanying investigation are addressed above.

In view of the above, the auditor finds BTC substantially compliant with 115.263.

Standard 115.264: Staff first responder duties

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

115.264 (a)

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser? X□ Yes □ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence? X□ Yes □ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? X□ Yes □ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? X□ Yes □ No

115.264 (b)

- If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff? X□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Administrator self reports the agency has a first responder policy for all allegations of sexual abuse. The Administrator further self reports the agency policy requires that upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report shall be required to:

Separate the alleged victim and abuser;
Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence;
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
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.

In the last 12 months, there was one allegation that a resident was sexually abused. There was zero allegations wherein the first security staff member to respond to the report separated the alleged victim and abuser. The fact pattern was such that the alleged incident had occurred on the previous day and there was no penetration or circumstances wherein the four tenets of 115.264(a) could be employed.

BTC Policy 13.11 entitled Coordinated Response/First Response Duties, pages 1 and 2, section II(A)(1, 6, 8, and 9) addresses 115.264(a).

The auditor did review the First Responder Checklist which was included with the PAQ information. The same is comprehensive in accordance with this standard and provides a solid reference for First Responders. Additionally, the BTC Coordinated Response to PREA Incidents flow chart corresponds with the aforementioned policy.

A synopsis of security staff and non-security staff first responder responses regarding 115.264(a) responsibilities is articulated in the narrative for 115.264(b). A synopsis of the responses of the 11 random staff interviewees is available in the narrative for 115.221(a).

The resident who reported a sexual abuse interviewee reports that immediately following his written report (emergency grievance submitted the following day), staff came to assist. The interviewee reports he felt the first responder acted quickly. Specifically, he was interviewed in the cos office and he subsequently documented a statement. The interviewee clearly articulated that no penetration occurred during the incident.

Pursuant to the PAQ, the Administrator self reports that 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. The Administrator further self reports that of the allegations that a resident was sexually abused during the last 12 months, there was zero instances wherein non-security staff responders were first on scene.

The cited BTC policy applies to all staff, volunteers, and contractors. Accordingly, there is no differentiation between security and non-security staff first responder duties and responsibilities.

Neither the security staff nor the non-security staff first responder interviewees accurately articulated the first responder duties as prescribed at 115.264(a). Specifically, one interviewee asserts the 1st responder requests that the victim not destroy physical evidence and asks the perpetrator to not destroy physical evidence. The other interviewee asserts that the 1st responder makes sure both the victim and perpetrator do not destroy physical evidence.

As the majority of random staff interviewed (inclusive of several non-security staff) accurately articulated 115.264(a) requirements, the auditor finds no basis for a non-compliance finding. The auditor does recom-

mend that the PM or applicable trainer accentuate the nuances of 1st responder duties during PREA ART, however.

In view of the above, the auditor finds BTC substantially compliant with 115.264.

Standard 115.265: Coordinated response

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

115.265 (a)

- Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse? X□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

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

BTC Policy 13.11 entitled Coordinated Response/Staff Response Duties, pages 1-9 addresses 115.265(a). The auditor has thoroughly reviewed this document and has determined the same is comprehensive and provides sufficient detail to guide staff through response to sexual abuse and sexual harassment incidents.

Additionally, the auditor has reviewed the BTC Coordinated Response to PREA Incidents matrix and finds the same to be another good resource for staff to utilize in response to sexual abuse incidents. The document is sufficiently posted to enable staff reference.

According to the Administrator, the facility does have a plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership in response to an incident of sexual abuse. The same is scripted in a local policy and staff are trained annually regarding the same.

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

Standard 115.266: Preservation of ability to protect residents from contact with abusers

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

115.266 (a)

- Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual

abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted? X□ Yes □ No

115.266 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Administrator self reports BTC has not entered into or renewed any collective bargaining agreement or other agreement since the last PREA audit.

The Administrator articulated in a memorandum dated March 31, 2021, that BTC and its administrators have not participated in any collective bargaining activities. Therefore, since there is no deviation from standard, the auditor finds BTC substantially compliant with 115.266.

Standard 115.267: Agency protection against retaliation

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

115.267 (a)

- Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff? X□ Yes □ No

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

115.267 (b)

- Does the agency employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations? X□ Yes □ No

115.267 (c)

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? X□ Yes □ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct

and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? X□ Yes □ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? X□ Yes □ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor any resident disciplinary reports? X□ Yes □ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident housing changes? X□ Yes □ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident program changes? X□ Yes □ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor negative performance reviews of staff? X□ Yes □ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor reassignments of staff? X□ Yes □ No

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

115.267 (d)

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

115.267 (e)

- If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation? X□ Yes □ No

115.267 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Administrator self reports the agency has a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff. The Administrator further self reports the agency designates staff member(s) with monitoring responsibilities for possible retaliation. The Administrator or in his absence, the PCM, and case managers are the designated retaliation monitors at BTC. The Administrator, or in his absence, the PCM, facilitate staff retaliation monitoring while case managers facilitate resident retaliation monitoring.

BTC Policy 14.9 entitled Findings, Sanctions, and False Reporting, page 3, section II(J)(1) addresses 115.267(a).

BTC Policy 13.9 entitled Findings, Sanctions, and False Reporting, page 3, section II(J)(2) addresses 115.267(b).

According to the Agency Head interviewee, movement of offenders from pod to pod, unit to unit, or facility to facility are some of the strategies available to protect residents from sexual abuse or sexual harassment and retaliation. Movement of staff from shift to shift, post to post, or facility to facility, along with a recommendation for the Employee Assistance Program are a few of the strategies available to protect staff from retaliation for sexual abuse or sexual harassment allegations.

According to the Administrator/retaliation monitor interviewee, the following measures can be implemented to protect residents and staff from retaliation when reporting allegations of sexual abuse or sexual harassment:

The case manager or the Administrator, PM facilitates formal meetings with the victim (dependent upon whether the victim is a resident or staff) on a bi-weekly basis for the first two months and monthly thereafter;
The aggressor is moved, possibly to another facility;
Minimally, staff perpetrators of retaliation could be given a post assignment or shift change or place the perpetrator on administrative leave;
Support services, inclusive of Employee Assistance Program (EAP) would be offered to staff victims;
Resident victims could be moved within the facility, possibly closer to staff supervision;
Increase welfare checks with respect to the resident victim.

Of note, the retaliation monitoring designee(s) reach out to the victim of sexual abuse subsequent to notification of the alleged abuse. The aforementioned retaliation monitoring meeting notes are documented on the Retaliation Monitoring form, in emails, and in progress notes.

The resident who reported a sexual abuse interviewee stated he feels protected enough against possible revenge from staff or other residents because he reported what happened to him.

Pursuant to the PAQ, the Administrator self reports the facility monitors the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff. Generally, retaliation monitoring continues for 90 days. The Administrator self reports the facility acts promptly to remedy any such retaliation.

The Administrator further self reports the facility continues such monitoring beyond 90 days if the initial monitoring indicates a continuing need. Extension of retaliation monitoring beyond 90 days occurred zero times throughout the last 12 months.

BTC Policy 13.9 entitled Findings, Sanctions, and False Reporting, pages 3 and 4, section II(J)(3)(a-c) addresses 115.267(c).

In regard to the measures to be taken when retaliation is suspected, the Administrator/retaliation monitoring interviewee asserts he would first assess the known facts. Subsequently, the situation would be investigated by the investigator. The outcome of the investigation will dictate subsequent steps.

In regard to warning signs of potential retaliation with respect to residents, changes in behavior, emotional changes, changes in associations, hygiene decompensation, isolation, and cessation of eating or changes in eating habits, and an increase in receipt of misconduct reports are all indicators of retaliation. With respect to staff, many of the above indicators, in addition to excessive call-offs, poor performance, and requests for shift and post changes are indicators of retaliation.

Retaliation monitoring is implemented for a minimum of 90 days. The Administrator asserts there is no maximum time in which retaliation monitoring is conducted and the same may be extended for the entire stay at BTC, if warranted.

Pursuant to the auditor's review of retaliation monitoring reports (eight 2018, one 2019, and one 2021 sets of retaliation monitoring documents) reveals the same are substantially compliant with both policy and standard provision.

BTC Policy 13.9 entitled Findings, Sanctions, and False Reporting, page 4, section II(J)(3)(a) addresses 115.267(d).

BTC Policy 13.9 entitled Findings, Sanctions, and False Reporting, page 3, section II(J)(2) addresses 115.267(e).

According to the Agency Head interviewee, if or when an individual who cooperates with an investigation expresses a fear of retaliation, the individual is monitored. The Administrator monitors such staff victim(s).

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

INVESTIGATIONS

Standard 115.271: Criminal and administrative agency investigations

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

115.271 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).) X□ Yes □ No □ NA

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).)
  X□ Yes □ No □ NA

115.271 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations as required by 115.234? X□ Yes □ No

115.271 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? X□ Yes □ No

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

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

115.271 (d)

- When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution? X□ Yes □ No

115.271 (e)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff? X□ Yes □ No

- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? X□ Yes □ No

115.271 (f)

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

- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? X□ Yes □ No

115.271 (g)

- Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible? X□ Yes □ No

115.271 (h)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution? X□ Yes □ No

115.271 (i)

- Does the agency retain all written reports referenced in 115.271(f) and (g) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years? X□ Yes □ No

115.271 (j)

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation? X□ Yes □ No

115.271 (k)

- Auditor is not required to audit this provision.

115.271 (l)

- When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.221(a).) X□ Yes □ No □ NA

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Administrator asserts the facility has a policy related to criminal and administrative agency investigations.

BTC Policy 13.10 entitled Investigations, page 1, section IV addresses 115.271(a).

According to the investigative staff interviewee, an investigation into an allegation of sexual abuse or sexual harassment is initiated immediately if he is on-site. During off-duty hours, he would report to the facility immediately and commence the investigation if directed to do so. In regard to an allegation of sexual harassment, he may not report to the facility however, he would follow-up regarding evidence known by the on-site supervisor. Sexual abuse cases are referred to BPD.

The BPD investigative interviewee asserts the criminal investigation is initiated instantaneously following receipt of the report from BTC officials. Evidence collection is initiated by the assigned investigator.

Both investigative interviewees assert that in regard to third-party or anonymous reports of sexual abuse or sexual harassment, the same are treated the same as any other investigation. The investigation is completed in a timely, thorough, and objective manner.

Pursuant to the auditor's review of 10 sexual abuse or sexual harassment investigations completed during the audit period, investigations appear to have been initiated in a timely manner.

BTC Policy 13.10 entitled Investigations, page 1, section V(A) addresses 115.271(b). This policy stipulates BTC shall use investigators that have received specialized training in handling sexual abuse and sexual harassment cases.

Policy reflects the Administrator and PCM are the designated PREA investigators at BTC. However, five investigators, inclusive of the Administrator and PCM, are properly trained and administrative sexual abuse/ harassment investigations may be delegated to the remaining three investigators.

The investigative staff interviewee reports he did receive training specific to conducting sexual abuse investigations in confinement settings. Specifically, he completed a three-hour on-line course presented by the National Institute of Corrections (NIC) entitled PREA: Investigating Sexual Abuse in a Confinement Setting. Additionally, the interviewee completed a 16 hour sexual abuse investigation training through BPD. Specifics regarding the criminal investigative staff interviewee's training are articulated in the narrative for 115.234.

BTC Policy 13.10 entitled Investigations, page 2, section V(C)(3) addresses 115.271(c).

The administrative investigative staff interviewee asserts the following steps are employed throughout the investigative process:

Check 1st Responder information. (five minutes)
Check crime scene, photographs or take photographs. (15-30 minutes)
Review victim, staff, and witness written statements. (30 minutes or 15 minutes per individual)
Facilitate threshold questioning of the victim. (15-30 minutes)
Review cameras. (one to three hours)
Re-interview victim, staff, witnesses dependent upon the situation. (15 minutes to two hours)
Review relevant medical documentation. (15-30 minutes)
If released for administrative investigation by BPD, interview perpetrator. (0- unknown)
Write report. (one to two hours).

The BPD investigative staff interviewee asserts the following steps are employed throughout the criminal investigative process:

Interview the victim. (30 minutes to one hour)
Check crime scene. (30 minutes to one hour)
Interview witnesses. (15 minutes to one hour)
Review cameras (live feed time). (15-30 minutes)
Review any relevant files provided by the administrative investigator. (30 minutes to one hour)
Possible re-interviews.
Review relevant medical documents.
Interview perpetrator. (zero to two hours)
Write report. (one hour to one week)

The administrative investigative interviewee further reports he is responsible for collecting video footage, written statements, interview notes, and files. The BPD investigator asserts he is responsible for collecting clothing, bedding, known objects as germane to the allegation, and DNA samples.

BTC Policy 13.10 entitled Investigations, page 2, section IV(B) addresses 115.271(d).

The investigative staff interviewee reports he does not consult with prosecutors. BPD investigators handle that aspect of the case. He asserts compelled interviews likewise fall under the jurisdiction of BPD.

The BPD investigator asserts he consults with the District Attorneys Office (DA) when legal issues present themselves.

BTC Policy 13.10 entitled Investigations, page 2, section V(C)(4 and 5) addresses 115.271(e).

The administrative and BPD investigative staff interviewees state residents, suspects, or witnesses are credible until proven otherwise. An analysis of the fact pattern and known facts compared against their statements establishes credibility. Further, in response to whether they would require a resident who alleges

sexual abuse to submit to a polygraph examination or truth-telling device as a condition for proceeding with an investigation, they state the same would be a BPD function.

The resident who reported a sexual abuse interviewee reports he was not required to take a polygraph examination as a condition for proceeding with a sexual abuse investigation.

BTC Policy 13.10 entitled Investigations, page 1, section V(A)(1)(a and b) addresses 115.271(f). This policy stipulates administrative investigations shall include an effort to determine whether staff actions or failures to act contributed to the abuse and 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.

The investigative staff interviewee reports he would assess staff actions in every investigation and would note any issues when staff actions or failure to act contributed to the sexual abuse. Comparison of staff actions and/or inactions against policies and the Code of Ethics is used to make such determinations.

He further stated administrative investigations are documented in written reports. The written report information is as follows:

Synopsis of allegation(s);
Timeline;
Synopsis of victim, witness, perpetrator statement(s);
Evidence credibility analysis;
Discussion of circumstantial, indirect evidence;
Facts and Findings; and
Conclusion.
The auditor notes that the BPD investigative staff interviewee likewise states the above topics are addressed in the criminal report.

The auditor reviewed one memorandum wherein the Administrator captures numerous contacts with BPD officials and investigators regarding a case that was investigated by BPD. The actual incident giving rise to the referral occurred on September 7, 2017.

The auditor's review of the above investigation reveals substantial compliance with 115.271(g). The investigator clearly documented that the alleged incident occurred subsequent to the resident's release from BTC.

When asked if criminal reports are documented, the investigative staff interviewee responded in the affirmative. He stated a criminal report would include everything he would include in an Administrative report, plus a description of and credibility assessment of physical evidence.

Pursuant to the PAQ, the Administrator self reports substantiated allegations of conduct that appear to be criminal are referred for prosecution by BPD investigator(s). The Administrator further self reports there were zero substantiated allegations of conduct that appeared to be criminal that were referred for prosecution since the last PREA audit.

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

BTC Policy 13.10 entitled Investigations, page 2, section V(D) addresses 115.271(i).

BTC Policy 13.10 entitled Investigations, page 1, section IV addresses 115.271(j).

According to the investigative staff interviewees, when a staff member alleged to have committed sexual abuse terminates employment prior to completion of an investigation into his/her conduct, the investigation

continues. The same is true when a victim who alleges sexual abuse or sexual harassment or an alleged abuser leaves the facility prior to completion of an investigation into the incident.

BTC Policy 13.10 entitled Investigations, page 2, section V(C)(2) addresses 115.271(l).

According to the Administrator, he would contact the investigating agency on a monthly basis, to stay informed of the progress of the sexual abuse investigation. The BTC PM asserts the Administrator facilitates all contact with BPD investigators to determine investigation progress. Contacts are documented in an email.

According to the BTC investigative staff interviewee, he would provide any investigative support required when an outside agency investigates an incident of sexual abuse in the facility.

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

Standard 115.272: Evidentiary standard for administrative investigations

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

115.272 (a)

- Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated? X□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

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

BTC Policy 13.10 entitled Investigations, page 3, section V(E) addresses 115.272(a).

The auditor's review of investigations addressed throughout this report reveals substantial compliance with 115.272(a).

According to the administrative investigative staff interviewee, the requisite standard of evidence for an administrative investigation is preponderance (more substantive evidence that the incident occurred, than not). The requisite standard of evidence for a criminal matter is “beyond a reasonable doubt.”

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

Standard 115.273: Reporting to residents

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

115.273 (a)

- Following an investigation into a resident's allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded? X□ Yes □ No

115.273 (b)

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

115.273 (c)

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit? X□ Yes □ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? X□ Yes □ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? X□ Yes □ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? X□ Yes □ No

115.273 (d)

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility? X□ Yes □ No

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility? X□ Yes □ No

115.273 (e)

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

115.273 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Administrator self reports the agency has a policy requiring any resident who makes an allegation that he or she suffered sexual abuse/harassment in an agency facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the agency. The Administrator further self reports that three criminal and/or administrative investigations of alleged resident sexual abuse were completed by the agency within the last 12 months and residents were notified verbally, or in writing, of the results of the investigation.

BTC Policy 13.10 entitled Investigations, page 3, section V(F)(1) addresses 115.273(a).

The auditor's review of five 2017/2018 sexual abuse/harassment investigations reveals the victim received 115.273(a) notifications regarding the status of the investigation (substantiated, unsubstantiated, unfounded) in two cases. In a third case, the investigator was unable to contact the third-party reporter and accordingly, absolutely zero facts could be gleaned. In the fourth case, the reporter was also a third-party reporter (not the victim) and he had been transferred to a ND DOCR facility. Of note, a 115.273(a) notification was forwarded to him at that facility. The CCCS PC asserts the requisite 115.273(a) notification was not provided in the fifth case.

The auditor's review of four 2019 investigations and one carry-over from 2018 reveals requisite 115.273(a) notifications were provided in all five cases. Additionally, the auditor's review of two 2020 staff-on-resident sexual abuse/harassment investigations reveals requisite 115.273(a) notifications were made to the victim. Finally, review of one 2021 investigation reveals the requisite notification was provided to the victim. Of note, the notification also reflects the perpetrator was charged with an administrative disciplinary offense.

According to the Administrator and investigative staff interviewee, the facility does notify a resident who makes an allegation of sexual abuse when the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation. The resident who reported a sexual abuse reports he believes the facility is required to notify him when his sexual abuse allegation has been substantiated, unsubstantiated, or unfounded.

Pursuant to the PAQ, the Administrator self reports that if an outside entity conducts such investigations, the agency requests the relevant information from the investigative entity in order to inform the resident of the outcome of the investigation. The Administrator further self reports one investigation of alleged resident sexual abuse in the facility was completed by an outside agency and the resident was notified verbally or in writing of the results of the same.

BTC Policy 13.10 entitled Investigations, page 3, section V(F)(2) addresses 115.273(b).

The auditor has found no evidence contradicting the above statements of the Administrator.

Pursuant to the PAQ, the Administrator self reports following a resident's allegation that a staff member has committed sexual abuse against the resident, the facility subsequently informs the resident (unless the agency has determined that the allegation is unfounded) whenever:

The staff member is no longer posted within the resident;s unit;

The staff member is no longer employed at the facility;
The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or
The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility.

The Administrator further self reports there has been a substantiated complaint (i.e. not unfounded) of sexual abuse committed by a staff member against a resident in an agency facility within the last 12 months. Upon the auditor;s review of the allegation and investigation, he finds the same was unfounded. Accordingly, 115.273(c) is not applicable to this investigation.

The Administrator self reports the agency subsequently informed the resident as articulated above. The auditor's review of the notification reveals the same notes the notification is not applicable to 115.273(c) requirements.

BTC Policy 13.10 entitled Investigations, page 3, section entitled V(G)(1-4) addresses 115.273(c).

The auditor's review of one 2018 and two 2019 staff-on-resident sexual abuse/harassment investigations reveals the requisite 115.273(c) notifications were made to the victim. Additionally, the auditor's review of two 2020 staff-on-resident investigations reveals requisite notifications were completed in both cases despite both cases being unfounded.

Pursuant to the PAQ, the Administrator self reports that following a resident's allegation he or she has been sexually abused by another resident in an agency facility, the agency subsequently informs the alleged victim whenever:

The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or
The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility.

BTC Policy 13.10 entitled Investigations, page 3, section V(H)(1 and 2) addresses 115.273(d).

The auditor's review of one 2019 sexual abuse/harassment investigation reveals the requisite 115.273(d) notification was provided to the resident. Additionally, as previously noted in the narrative for 115.273(a), notification of administrative disciplinary charge was provided with respect to one 2021 report.

The resident who reported a sexual abuse states he did receive 115.273(d) notification following conclusion of the investigation into his allegation.

Pursuant to the PAQ, the Administrator self reports the agency has a policy that all notifications to residents described under this standard are documented. The Administrator further self reports in the last 12 months, three notifications to residents were provided pursuant to this standard and all were documented.

BTC Policy 13.10 entitled Investigations, page 4, section V(I) addresses 115.273(e).

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

DISCIPLINE

Standard 115.276: Disciplinary sanctions for staff

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

115.276 (a)

- Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? X□ Yes □ No

115.276 (b)

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

115.276 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories? X□ Yes □ No

115.276 (d)

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies unless the activity was clearly not criminal? X□ Yes □ No

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies? X□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Administrator self reports staff is subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

BTC Policy 13.9 entitled Findings, Sanctions, and False Reporting, page 2, section II(H) addresses 115.276(a).

The auditor has not discovered any substantiated cases wherein staff perpetrated sexual abuse/harassment while the victim was confined at BTC.

Pursuant to the PAQ, the Administrator self reports in the last 12 months, zero facility staff have violated agency sexual abuse or sexual harassment policies and have been terminated or resigned prior to termination.

BTC Policy 13.9 entitled Findings, Sanctions, and False Reporting, page 2, section II(H)(1) addresses 115.276(b).

Pursuant to the PAQ, the Administrator self reports disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. The Administrator further self reports in the last 12 months, zero facility staff have been disciplined, short of termination, for violation of agency sexual abuse or sexual harassment policies.

BTC Policy 13.9 entitled Findings, Sanctions, and False Reporting, pages 2 and 3, section II(H)(2) addresses 115.276(c).

Pursuant to the PAQ, the Administrator self reports all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. The Administrator further self reports in the last 12 months, zero facility staff have been reported to law enforcement or licensing boards following their termination (or resignation prior to termination) for violating agency sexual abuse or sexual harassment policies.

BTC Policy 13.9 entitled Findings, Sanctions, and False Reporting, page 3, section II(H)(3) addresses 115.276(d).

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

Standard 115.277: Corrective action for contractors and volunteers

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

115.277 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? X□ Yes □ No

- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies unless the activity was clearly not criminal? X□ Yes □ No

- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? X□ Yes □ No

115.277 (b)

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents? X□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Administrator self reports any contractor or volunteer who engages in sexual abuse is 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. The Administrator further self reports agency policy requires that any contractor or volunteer who engages in sexual abuse with residents is prohibited from contact with residents. In the last 12 months, zero contractors or volunteers have been reported to law enforcement agencies and relevant licensing bodies for engaging in sexual abuse of residents.

BTC Policy 13.9 entitled Findings, Sanctions, and False Reporting, page 3, section II(I)(1) addresses 115.277(a).

The auditor's review of memorandums dated 2018, 2019, and 2021 reveals zero contractors/volunteers have engaged in sexual abuse of a resident during the audit period.

Pursuant to the PAQ, the Administrator self reports the facility takes appropriate remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

BTC Policy 13.9 entitled Findings, Sanctions, and False Reporting, page 3, section II(I)(2) addresses 115.277(b).

The Administrator asserts that in the case of any violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, a designated facility investigator would investigate the matter and he (the Administrator) would suspend facility access privileges. No contact would be allowed with residents pending conclusion of the investigation. The Administrator further self reports no such incidents have occurred within the last 12 months.

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

Standard 115.278: Interventions and disciplinary sanctions for residents

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

115.278 (a)

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, are residents subject to disciplinary sanctions pursuant to a formal disciplinary process? X□ Yes □ No

115.278 (b)

- Are sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories? X□ Yes □ No

115.278 (c)

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior? X□ Yes □ No

115.278 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to require the offending resident to participate in such interventions as a condition of access to programming and other benefits? X□ Yes □ No

115.278 (e)

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? X□ Yes □ No

115.278 (f)

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? X□ Yes □ No

115.278 (g)

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Administrator self reports residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on- resident sexual abuse. The Administrator further self reports residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following a criminal finding of guilt for resident-on-resident sexual abuse. In the last 12 months, zero administrative and criminal findings of resident-on-resident sexual abuse have occurred at BTC.

BTC Policy 13.9 entitled Findings, Sanctions, and False Reporting, page 1 and 2, section II(C) addresses 115.278(a).

BTC Policy 13.9 entitled Findings, Sanctions, and False Reporting, page 2, section II(C)(1-3) addresses 115.278(b).

According to the Administrator, an allegation of sexual abuse is referred to BPD for investigation. Simultaneously, a request for administrative removal of the perpetrator is submitted to ND DOCR. ND DOCR staff are responsible to address any disciplinary matters, inclusive of ensuring that sanctions are commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary

history, and the sanctions imposed for comparable offenses by other residents with similar histories. Additionally, mental disability or mental illness is considered by ND DOCR staff when determining sanctions.

BTC Policy 13.9 entitled Findings, Sanctions, and False Reporting, page 2, section II(D)and (D)(1) addresses 115.278(c).

Pursuant to the PAQ, the Administrator asserts the facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse. However, as reflected in the narrative for 115.27(b), the perpetrator is generally removed from the facility via administrative removal. ND DOCR staff may subsequently impose removal as an administrative disciplinary sanction.

In view of the above, the Administrator further asserts if the receiving facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse, they may consider whether to require the offending resident to participate in such interventions as a condition of access to programming or other benefits.

BTC Policy 13.9 entitled Findings, Sanction, and False Reporting, page 2, section II(D) and (D)(2 and 3) addresses 115.278(d).

The CCCS PC asserts zero medical or mental health staff are employed at BTC.

Pursuant to the PAQ, the Administrator self reports the agency disciplines residents for sexual conduct with staff only upon finding that the staff member did not consent to such contact.

BTC Policy 13.9 entitled Findings, Sanctions, and False Reporting, page 2, section II(G) addresses 115.278(e).

In memorandums dated 2018, 2019, and 2021, the Administrator self reports zero instances of resident-on-staff cases have occurred at BTC during the audit period.

Pursuant to the PAQ, the Administrator self reports the agency prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation.

BTC Policy 13.9 entitled Findings, Sanctions, and False Reporting, page 2, section II(E) addresses 115.278(f).

Pursuant to the auditor's review of sexual abuse investigations as referenced throughout this report, he has not identified any instances of 115.278(f) violations. Additionally, he has received no resident allegations of 115.278(f) violations, either on-site or pursuant to letters received prior to the on-site audit.

Pursuant to the PAQ, the Administrator self reports the agency prohibits all sexual activity between residents. The Administrator further self reports BTC deems sexual activity between residents to constitute sexual abuse only if it determines the activity is coerced and at that point, disciplinary action may ensue.

BTC Policy 13.9 entitled Findings, Sanctions, and False Reporting, page 2, section II(F) addresses 115.278(g).

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

MEDICAL AND MENTAL CARE

Standard 115.282: Access to emergency medical and mental health services

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

115.282 (a)

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment?
  X□ Yes □ No

115.282 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do security staff first responders take preliminary steps to protect the victim pursuant to § 115.262? X□ Yes □ No

- Do security staff first responders immediately notify the appropriate medical and mental health practitioners? X□ Yes □ No

115.282 (c)

- Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate? X□ Yes □ No

115.282 (d)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?
  X□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Administrator self reports resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The Administrator further self reports the nature and scope of such services are determined by medical and mental health practitioners according to their professional judgment. Medical and mental health staff maintain secondary materials (e.g., forms, logs) documenting the timeliness of emergency medical treatment and crisis intervention services that were provided; the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; and the provision of appropriate and timely information and services concerning contraception and sexually transmitted infection prophylaxis.

BTC Policy 13.5 entitled Medical and Mental Health, pages 1 and 2, section II(B) addresses 115.282(a). Policy 13.11 entitled Coordinated Response/First Response Duties, pages 4 and 5, section II(C) also addresses 115.282(a). This policy defines the steps to be taken to ensure compliance with 115.282(a).

As mentioned in the narrative for 115.278, the CCCS PC asserts zero medical or mental health staff are employed at BTC. Accordingly, interviews with such staff could not be conducted.

The resident who reported a sexual abuse reported he refused medical/mental health evaluation subsequent to reporting the incident of sexual abuse. He further reported he did not incur any physical injury.

The provisions of 115.282(b) are addressed in the narrative for 115.264(b). Medical and mental health staff are not employed by CCCS at BTC. Accordingly, medical treatment pursuant to this standard falls under the purview of clinicians at local hospital(s). The nature and scope of treatment fall exclusively under the purview of their licenses and certifications.

The discussion as articulated in the policy narratives mentioned in 115.262(a) clearly addresses action steps to be taken by First Responders/Supervisors in terms of hospital contact and escort to the hospital(s).

Pursuant to the PAQ, the Administrator self reports resident victims of sexual abuse while incarcerated are offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. Medical and mental health staff maintain secondary materials (e.g., forms, logs) documenting the timeliness of emergency medical treatment and crisis intervention services that were provided; the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; and the provision of appropriate and timely information and services concerning contraception and sexually transmitted infection prophylaxis.

The elements of this provision are addressed in the policy citations reflected in the narrative for 115.282(a).

The resident who reported a sexual abuse interviewee was not subject to a forensic examination. Additionally, the fact pattern of the allegation did not warrant 115.282(c) interventions.

Pursuant to the PAQ, the Administrator self reports treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

BTC Policy 13.5 entitled Medical and Mental Health, pages 2 and 3, section II(C)(2) addresses 115.282(d).

While no incidents arose during this audit period wherein the requirements of 115.282 were invoked, there are minimal policy steps that link tasks to ensure compliance with the standard. The combination of the aforementioned two policies generally addresses all tenets of the standard.

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

Standard 115.283: Ongoing medical and mental health care for sexual abuse victims and abusers

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

115.283 (a)

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility? X□ Yes □ No

115.283 (b)

- Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody? X□ Yes □ No

115.283 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? X□ Yes □ No

115.283 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if "all-male" facility. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) X□ Yes □ No □ NA

115.283 (e)

- If pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if "all-male" facility. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) X□ Yes □ No □ NA

115.283 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? X□ Yes □ No

115.283 (g)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? X□ Yes □ No

115.283 (h)

- Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? X□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Administrator self reports the facility offers medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility.

BTC Policy 13.5 entitled Medical and Mental Health, page 2, section II(C) addresses 115.283(a).

The BTC PM asserts she is aware of a 2019 incident wherein a resident reported being victimized by sexual abuse in a prison, jail, lockup, or juvenile facility. The screening tool is reflective of the report and follow-up emails, etc. were included in the packet. The victim's declination of medical/mental health services is clearly documented by the PM on the screening tool.

BTC Policy 13.5 entitled Medical and Mental Health, page 2, section II(C)(1) addresses 115.283(b).

The resident who reported a sexual abuse interviewee reports he declined medical/mental health staff follow-up.

Pursuant to memorandums dated 2018, 2019, and 2021, zero 115.283(a) incidents required 115.283(b) interventions.

It is noted according to policy, medical and mental health services are provided to female residents by ND DOCR and male residents access medical and mental health services in the community. Given the same, there is an expectation and understanding that the medical and mental health services provided are consistent with the community level of care.

Pursuant to the PAQ, the Administrator self reports female victims of sexually abusive vaginal penetration while incarcerated are offered pregnancy tests.

CCCS Policy 1.3.5.12 entitled PREA, page 23, section 115.283(d) addresses 115.283(d). This policy is also validated pursuant to BTC Policy 13.5 entitled Medical and Mental Health, pages 2 and 3, section II(C)(2 and 3).

As the resident who reported a sexual abuse interviewee is a male, 115.283(d) requirements are not applicable to his interview.

Pursuant to the PAQ, the Administrator self reports if pregnancy results from sexual abuse while incarcerated, victims receive timely and comprehensive information about, and timely access to, all lawful pregnancy-related medical services.

CCCS Policy 1.3.5.12 entitled PREA, page 23, section 115.283(e) addresses 115.283(e).

As the resident who reported a sexual abuse interviewee is a male, 115.283(e) requirements are not applicable to his interview.

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

The policy citation referenced in the narrative for 115.283(d) above (BTC Policy 13.5) is also applicable to 115.283(f).

As previously indicated, the resident who reported a sexual abuse interviewee reports the fact pattern in his allegation did not include any penetration or skin-to-skin contact. Accordingly, 115.283(f) requirements are not applicable to his interview.

Pursuant to the PAQ, the Administrator self reports treatment services are provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

The policy addressing this provision is clearly articulated in the narrative for 115.283(d) as reflected above.

The resident who reported a sexual abuse interviewee reports he did not have to pay for any treatment related to this incident of sexual abuse.

Pursuant to the PAQ, the Administrator self reports the facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history, and offers treatment when deemed appropriate by mental health practitioners.

BTC Policy 13.5 entitled Medical and Mental Health, page 3, section II(C)(4) addresses 115.283(h).

Pursuant to conversation with the PM, it has been learned no resident-on-resident abusers have been housed at BTC since the last PREA audit. It is again noted that the Administrator has the ability to decline acceptance of residents based on historical information, inclusive of resident-on-resident sexual abuse.

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

DATA COLLECTION AND REVIEW

Standard 115.286: Sexual abuse incident reviews

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

115.286 (a)

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded? X□ Yes □ No

115.286 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? X□ Yes □ No

115.286 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? X□ Yes □ No

115.286 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? X□ Yes □ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? X□ Yes □ No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? X□ Yes □ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? X□ Yes □ No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? X□ Yes □ No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.286(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? X□ Yes □ No

115.286 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? X□ Yes □ No

Auditor Overall Compliance Determination

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

Pursuant to the PAQ, the Administrator self reports the facility conducts a sexual abuse incident review at the conclusion of every criminal or administrative sexual abuse and sexual harassment investigation, unless the allegation has been determined to be unfounded.

The Administrator further self reports in the last 12 months, one criminal and/or administrative investigation of alleged sexual abuse/harassment was completed at the facility, excluding only "unfounded" incidents. Two 2020 investigations were determined to be unfounded.

BTC Policy 13.7 entitled Data Collection, Aggregation and Review, page 1, section II(A)(1)(a) addresses 115.286(a). This policy stipulates BTC shall conduct a sexual abuse incident review at the conclusion of every criminal or administrative sexual abuse or sexual harassment investigation including whether or not the allegation has not been substantiated, unless the allegation has been determined to be unfounded. The review will include members of the Sexual Assault Review Team (SART).

Pursuant to the PAQ, the Administrator self reports the facility ordinarily conducts a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse/harassment investigation. The Administrator further self reports in the last 12 months, one criminal and/or administrative investigation of alleged sexual abuse/harassment was completed at the facility and was followed by a sexual abuse incident review within 30 days, excluding only "unfounded" incidents.

BTC Policy 13.7 entitled Data Collection, Aggregation and Review, page 1, section II(A)(1)(b) addresses 115.286(b). This policy stipulates such review shall occur within 30 days of the conclusion of the investigation.

Pursuant to the PAQ, the Administrator self reports the SART team includes upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners.

BTC Policy 13.7 entitled Data Collection, Aggregation and Review, page 1, section II(A)(1)(c) addresses 115.286(c). This policy stipulates the SART team includes the following; BTC PM, Administrator, cos, shift supervisor, and PREA investigators.

As previously noted in 115.282, CCCS employs no medical or mental health practitioners at BTC. Accordingly, there is no medical or mental health presence on the SART team.

According to the Administrator, there is a facility SART team comprised of upper-level management officials. Additionally, input is allowed from line supervisors and investigators. There are no medical/mental health providers at BTC.

Pursuant to the PAQ, the Administrator asserts the review team shall:

Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse;
Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility;

Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;
Assess the adequacy of staffing levels in that area during different shifts;
Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and
Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to the above paragraphs of this section, and any recommendations for improvement and submit such report to the facility head and PREA Coordinator.

BTC Policy 13.7 entitled Data Collection, Aggregation and Review, pages 1 and 2, section II(A)(1)(d) addresses 115.286(d).

The auditor's review of eight completed 2018, 2019, and 2021 SART Checklist Forms associated with investigative findings reveals substantial compliance with 115.286(a-d).

The Administrator advises that the team uses the information from the SART review to determine what was done correctly and what was done incorrectly. What were the causal factors? How do we improve?

According to the Administrator, the SART team does:

Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility;
Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;
Assess the adequacy of staffing levels in that area during different shifts; and
Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff.

The SART Reports reviewed by the auditor clearly address all considerations required by 115.286(d).

The PM asserts the facility conducts SART reviews and prepares a report of its findings from the reviews, including any determinations and any recommendations for improvement. The reports are forwarded to her for review and signature. She employs quality control with respect to the report and follows up to ensure recommendations are followed or documented as to the rationale for not following the same. She has noted no trends in terms of the allegations and reports reviewed.

According to the Incident Review Team interviewee, the SART team:

Considers whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility;
Examines the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;
Assesses the adequacy of staffing levels in that area during different shifts; and
Assesses whether monitoring technology should be deployed or augmented to supplement supervision by staff.

The auditor noted two SART reviews wherein corrective action was recommended. Both have been validated by the auditor.

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

BTC Policy 13.7 entitled Data Collection, Aggregation and Review, page 2, section II(A)(1)(e) addresses 115.286(e).

The auditor notes there was one completed recommendation each in one 2018 and one 2019 Sexual Assault Response Team Checklists. The auditor did not identify any additional reports wherein recommendations were articulated.

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

Standard 115.287: Data collection

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

115.287 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? X□ Yes □ No

115.287 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually? X□ Yes □ No

115.287 (c)

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? X□ Yes □ No

115.287 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews? X□ Yes □ No

115.287 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) □ Yes □ No X□ NA

115.287 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.) X□ Yes □ No □ NA

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Administrator self reports 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. The Administrator further self reports the standardized instrument includes, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice.

BTC Policy 13.7 entitled Data Collection, Aggregation and Review, page 2, section II(A)(2) addresses 115.287(a)(c). This policy stipulates BTC shall collect accurate, uniform data for every allegation of sexual abuse and sexual harassment using the standardized instrument known as the Survey of Sexual Violence (SSV) and it will be collected annually. If the SSV data collection is not conducted by the Bureau of Justice Statistics, the following data shall be collected:

The number of incidents that met the definition of sexual abuse and sexual harassment as outlined in the PREA Standards;
The area where the incident occurred;
The time of the incident;
The victim's age, ethnicity, and gender;
The type of abuse or injury;
How the incident was reported;
If the incident was resident-on resident, staff-on-resident, or resident-on-staff;
The perpetrator's age, ethnicity, and gender;
The nature of the incident; and
Sanctions imposed on the perpetrator.

The auditor's review of the CCCS website reveals requisite BTC 115.287(a/c) information is captured in the 2018, 2019, and 2020 BTC Annual PREA Reports.

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

Pursuant to the PAQ, the Administrator self reports the agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

BTC Policy 13.7 entitled Data Collection, Aggregation and Review, page 3, section II(A)(3) addresses 115.287(d).

The auditor's review of files mentioned throughout this report and comparison against annual PREA reports reveals substantial compliance with 115.287(d).

Pursuant to the PAQ, the Administrator self reports the agency does not obtain incident-based and aggregated data from private facilities with which BTC contracts for the confinement of its residents. Specifically, BTC does not enter into such contracts. Accordingly, this provision is deemed to be NA.

Pursuant to the PAQ, the Administrator self reports the agency has provided the Department of Justice (DOJ) with data from the previous calendar year upon request. Specifically, the DOJ has made such a request for 2020 data.

It is noted BTC Policy 13.7 entitled Data Collection, Aggregation and Review, page 3, section II(A)(5) addresses 115.287(f).

The auditor's review of the 2020 SSV reveals substantial compliance with 115.287(f).

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

Standard 115.288: Data review for corrective action

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

115.288 (a)

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? X□ Yes □ No

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? X□ Yes □ No

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? X□ Yes □ No

115.288 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse X□ Yes □ No

115.288 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? X□ Yes □ No

115.288 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? X□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Administrator self reports the agency reviews data collected and aggregated pursuant to 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, and training, including:

Identifying problem areas;

Taking corrective action on an ongoing basis; and
Preparing an annual report of its findings from its data review and any corrective actions for each facility, as well as, the agency as a whole.

BTC Policy 13.7 entitled Data Collection, Aggregation and Reviews, page 3, section II(B)(1)(a-c) addresses 115.288(a). This policy stipulates BTC shall review data collected and aggregated pursuant to this section in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including:

Identifying problem areas;
Taking corrective action; and
Preparing an annual report of its findings and corrective actions for each facility, as well as, the agency as a whole.

According to the Agency Head interviewee, incident-based sexual abuse data statistics are reviewed to identify/evaluate any patterns. If policy or training modifications are necessary as the result of any trends or patterns, the same would be implemented.

According to the BTC PM, data is collected and aggregated and is reviewed in order to assess and improve the effectiveness of sexual abuse prevention, detection, and response policies and training. Findings are compiled in an annual report and trends are assessed. The primary objective is to evaluate ways to improve.

Data (hard copies of sexual abuse/harassment investigations and all sexual victimization/aggressor assessments/reassessments) is secured in a locked file cabinet in the PM's Office and the office is secured when she is not in the office. An electronic copy of all investigations is forwarded to the CCCS PC. The facility and agency does take action on an ongoing basis based on the data.

An annual PREA report is prepared by the Administrator and reviewed by the PM. The document is subsequently forwarded to the CCCS PC for review and publication after review by the CCCS CEO. The annual report captures findings from the data review and any corrective actions implemented at BTC.

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

BTC Policy 13.7 entitled Data Collection, Aggregation and Review, page 3, section II(B)(2) addresses 115.288(b).

The auditor finds that while there is a comparison between each year in terms of data, there is no assessment of necessary changes and the status of those changes on an annual basis. As previously indicated, SART reviews were conducted on a fairly consistent basis however, the status of camera installation, etc. is not reflected in any of the audit period reports. Since at least one SART recommendation focused on movement and repositioning of one camera, the same should have been mentioned in the annual report. Accordingly, the auditor finds the same to be non-compliant with 115.288(b).

In view of the above, the auditor is imposing a 180-day corrective action period wherein BTC will ensure that SART and routine PREA corrective actions are addressed in the amended 2020 annual report. Henceforth, corrective actions from prior years and an assessment of the agency's progress in addressing sexual abuse will be included in the respective annual reports. Since the Administrator writes the annual report, additional training is not required.

The completion due date for this corrective action is December 13, 2021.

June 16, 2021 Update:

The PM provided the auditor with the amended 2020 annual report, complete with all requisite information prescribed in 115.288(b). As previously referenced, the auditor recommended installation of a mirror system to address blind spots within the facility. Mirrors have been ordered with installation scheduled upon delivery.

In addition to the above, unannounced PREA rounds have been implemented at BTC since the last audit. Administrators facilitate such rounds on all shifts and the same are documented. The auditor notes the same appears to have a positive impact on incident reduction.

In view of the above, the auditor now finds BTC substantially compliant with 115.288(b).

Pursuant to the PAQ, the Administrator self reports 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.

BTC Policy 14.7 entitled Data Collection, Aggregation and Review, page 3, section II(B)(3) addresses 115.288(c).

According to the Agency Head interviewee, he does sign and approve such annual reports.

Pursuant to the auditor's review of the aforementioned BTC Annual PREA Reports, there is indication the Agency Head approved the same.

Pursuant to the PAQ, the Administrator self reports that when the agency redacts material from an annual report for publication, the redactions are limited to specific materials where publication would present a clear and specific threat to the safety and security of the facility. The Administrator further self reports the agency indicates the nature of the material redacted.

BTC Policy 13.7 entitled Data Collection, Aggregation and Review, page 3, section II(B)(4) addresses 115.288(d).

According to the BTC PM, personal identifiers (names and identifying data) would typically be redacted from the annual report. She further self reports that the nature of the material redacted would be identified.

In view of the above, the auditor finds BTC is now substantially compliant with 115.288.

Standard 115.289: Data storage, publication, and destruction

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

115.289 (a)

- Does the agency ensure that data collected pursuant to § 115.287 are securely retained? X□ Yes □ No

115.289 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? X□ Yes □ No

115.289 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? X□ Yes □ No

115.289 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? X□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Administrator self reports the agency shall ensure that data collected pursuant to 115.287 is securely maintained.

BTC Policy 13.7 entitled Data Collection, Aggregation and Review, page 4, section II(C)(1) addresses 115.289(a).

During the facility tour and throughout the audit period, the auditor did find compliance as described by the Administrator.

According to the BTC PM, data is collected and aggregated and is reviewed in order to assess and improve the effectiveness of sexual abuse prevention, detection, and response policies and training. Findings are compiled in an Annual Report and trends are assessed. The primary objective is to evaluate ways to improve.

Data (hard copies of sexual abuse/harassment investigations and all sexual victimization/aggressor assessments/reassessments) is secured in a locked file cabinet in the BTC PM's Office and the office is secured when she is not in the office. An electronic copy of all investigations is forwarded to the CCCS PC. The facility and agency does take action on an ongoing basis based on the data.

Pursuant to the PAQ, the Administrator self reports agency policy requires that aggregated sexual abuse data from facilities under its direct control and private facilities with which it contracts be made readily available to the public, at least annually, through its website.

BTC Policy 13.7 entitled Data Collection, Aggregation and Review, page 4, section II(C)(2) addresses 115.289(b).

The auditor's review of the CCCS and BTC website reveals substantial compliance with 115.289(b). As previously indicated, neither CCCS nor BTC contract with other entities to house residents designated for confinement at BTC.

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

BTC Policy 13.7 entitled Data Collection, Aggregation and Review, page 4, section II(C)(3) addresses 115.289(c).

The auditor's review of the aggregated sexual abuse data reveals no identifiers.

Pursuant to the PAQ, the Administrator self reports the agency maintains sexual abuse data collected pursuant to 115.287 for at least 10 years after the date of initial collection unless federal, state, or local law requires otherwise.

BTC Policy 13.7 entitled Data Collection, Aggregation and Review, page 4, section II(C)(4) addresses 115.289(d).

The auditor has randomly scanned some of the investigative files covering the last six years, complete with supporting documentation and data, and finds the same to substantiate compliance with 115.289(d).

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

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

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

115.401 (a)

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

115.401 (b)

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

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

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

115.401 (h)

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

115.401 (i)

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

115.401 (m)

- Was the auditor permitted to conduct private interviews with residents? X□ Yes □ No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? X□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

Both BTC and CCCS staff were diligent in providing the auditor requested information. Provision of this information greatly enhanced the audit process and allows for creation of a path forward in terms of PREA compliance and resident sexual safety.

BTC staff were very facilitative in terms of facilitation of on-site tasks. Interviews, documentation reviews, and the facility tour were conducted in an efficient manner. Additionally, the PCM's diligence in terms of clarification was invaluable to the auditor, providing a better picture of PREA programs and operations at BTC.

Standard 115.403: Audit contents and findings

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

115.403 (f)

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

Auditor Overall Compliance Determination

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

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

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

None.

AUDITOR CERTIFICATION

I certify that:

X□ The contents of this report are accurate to the best of my knowledge.

X □ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

X□ I have not included in the final report any personally identifiable information (PII) about any resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.[1] Auditors are not permitted to submit audit reports that have been scanned.[2] See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Kenneth E. Arnold **August 11, 2021**

Auditor Signature **Date**

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

[2] See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.