

PREA Facility Audit Report: Final

Name of Facility: BVCASA Transitional Treatment Center

Facility Type: Community Confinement

Date Interim Report Submitted: 04/10/2017

Date Final Report Submitted: 07/17/2017

Auditor Certification	
The contents of this report are accurate to the best of my knowledge.	<input checked="" type="checkbox"/>
No conflict of interest exists with respect to my ability to conduct an audit of the agency under review.	<input checked="" type="checkbox"/>
I have not included in the final report any personally identifiable information (PII) about any inmate/resident/detainee or staff member, except where the names of administrative personnel are specifically requested in the report template.	<input checked="" type="checkbox"/>
Auditor Full Name as Signed: Kyle D. Barrington	Date of Signature: 07/17/2017

AUDITOR INFORMATION	
Auditor name:	Barrington, Kyle
Address:	
Email:	Kyle.Barrington@Zajonc-Corp.com
Telephone number:	
Start Date of On-Site Audit:	02/22/2017
End Date of On-Site Audit:	02/24/2017

FACILITY INFORMATION	
Facility name:	BVCASA Transitional Treatment Center
Facility physical address:	405 W. 28th Street, Bryan, Texas - 77803
Facility Phone	
Facility mailing address:	
The facility is:	<input type="radio"/> County <input type="radio"/> Federal <input type="radio"/> Municipal <input checked="" type="radio"/> State <input type="radio"/> Military <input type="radio"/> Private for profit <input type="radio"/> Private not for profit
Facility Type:	<input checked="" type="radio"/> Community Treatment Center <input type="radio"/> Halfway house <input type="radio"/> Restitution center <input type="radio"/> Alcohol or drug rehabilitation center <input type="radio"/> Mental health facility <input type="radio"/> Other community correctional facility

Primary Contact			
Name:	Crystal Crowell	Title:	Executive Director
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Facility Director			
Name:	Crystal Crowell	Title:	Executive Director
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Facility PREA Compliance Manager			
Name:	Dena Horsman	Email Address:	dhorsman@bvcasa.org

Facility Health Service Administrator			
Name:		Title:	
Email Address:		Telephone Number:	

Facility Characteristics			
Designed facility capacity:		183	
Current population of facility:		178	
Age Range	<i>Adults: 18-80</i>	<i>Juveniles:</i>	<i>Youthful Residents:</i>
Facility security level/resident custody levels:		Low	
Number of staff currently employed at the facility who may have contact with residents:		72	

AGENCY INFORMATION	
Name of agency:	Brazos Valley Council on Alcohol and Substance Abuse
Governing authority or parent agency (if applicable):	
Physical Address:	4001 E. 29th Street , Ste. 90, Bryan, Texas - 77802
Mailing Address:	
Telephone number:	

Agency Chief Executive Officer Information:			
Name:		Title:	
Email Address:		Telephone Number:	

Agency-Wide PREA Coordinator Information			
Name:	Brittany Robinson	Email Address:	brobinson@bvccasa.org

AUDIT FINDINGS

Narrative:

The auditor's description of the audit methodology should include a detailed description of the following processes during the pre-audit, on-site audit, and post-audit phases: documents and files reviewed, discussions and types of interviews conducted, number of days spent on-site, observations made during the site-review, and a detailed description of any follow-up work conducted during the post-audit phase. The narrative should describe the techniques the auditor used to sample documentation and select interviewees, and the auditor's process for the site review.

The Brazos Valley Council on Alcohol and Substance Abuse (BVCASA) requested a PREA Audit for the agency's sole facility, called the BVCASA Transitional Treatment Center (TTC), which is in Bryan, Texas on December 15, 2016. The pre-audit work began on December 19, 2016 and the onsite portion of the PREA Audit was conducted between February 22, 2017, and February 24, 2017. (NOTE: For the purposes of this PREA Report the term "Agency" always refers to the BVCASA and the term "Facility" always refers to the TTC).

The Data Audit Framework used by this Auditor to assess the Agency's and Facility's compliance with the PREA Standards included the following: (1) Agency policies, (2) Facility procedures, (3) Interviews with 43 persons [eight (8) specialized staff, 17 security staff and 18 residents], (4) the Pre-Audit Questionnaire, (5) 40 client files, (6) 24 staff files and (7) associated attachments. Further, the Data Audit Framework relied on interviews of local area service providers (local area rape crisis center and local hospitals that would be used for forensic exams).

AUDIT FINDINGS

Facility Characteristics:

The auditor's description of the audited facility should include details about the type of the facility, demographics and size of the inmate or resident population, numbers and type of staff positions, configuration and layout of the facility, numbers of housing units, description of housing units including any special housing units, a description of programs and services, including food service and recreation.

The BVCASA's Transitional Treatment Center (also known as the Facility) is in an urban area of Bryan, Texas and comprises approximately one city block and is encompassed by a wooden and iron fence around three sides. Two (2) main buildings and two "out buildings" comprise the facility. The two (2) main buildings are the (1) Horizon Building and (2) McCaffrey Building. The Horizon Building can house 158 females, aged 18 to 80, and the McCaffrey House can house up to 25 male residents, aged 18 to 80. Collectively, the Facility can house up to 183 minimum-security, or low-risk, residents. All residents at the Facility have been sent by the Texas Department of Criminal Justice (TDCJ). At the time of the onsite audit portion of this PREA Audit there were 172 residents at the Facility (19 males and 153 females). To accommodate these residents, the Facility employs approximately 72 staff positions of which all 72 are considered "security" staff for the staff-to-resident ratio, as defined by PREA.

The Horizon Building is a four-story structure (when the basement is included) that contains resident living areas, staff offices, group rooms, storage, maintenance, laundry rooms, and a kitchen. Visitors pass through a lobby area at the main entrance. Residential living areas are located on the third and fourth floors with group rooms, offices, and kitchen comprising much of the basement and first floor. The Horizon Building also houses a local governmental community services department in one area of the first floor. The McCaffrey Building is a one-story structure containing resident living areas, staff offices, group rooms, storage, and laundry rooms. There are 14 video cameras in the Horizon Building and four (4) security cameras at the McCaffrey Building. A tour of the Facility noted that none of these cameras are located within a living area where residents may be showering, changing clothes and/or performing bodily functions. Further, the facility does not have any "isolation cells" as all residents live in rooms on bunk beds. Residents are not under constant supervision as residents are expected to be employed in the local community. There are multiple areas that are considered blind spots from the camera system and the agency does not maintain a list of these blind spots. Upper level administrative staff have administrative rights to the cameras and the digitized records.

Routine medical care is provided offsite via contract nurses and contract doctors. Mental health services are provided offsite by the contracted counselors and therapists. At the time of the onsite audit portion of this PREA Audit there were a total of 29 volunteers and zero (0) contractors authorized to enter the Facility. The Facility had never had a previous PREA Audit.

AUDIT FINDINGS

Summary of Audit Findings:

The summary should include the number of standards exceeded, number of standards met, and number of standards not met, along with a list of each of the standards in each category. If relevant, provide a summarized description of the corrective action plan, including deficiencies observed, recommendations made, actions taken by the agency, relevant timelines, and methods used by the auditor to reassess compliance.

Number of standards exceeded:	0
Number of standards met:	41
Number of standards not met:	0

Prior to the onsite audit, which occurred on February 22, 2017 and ended on February 24, 2017, it was confirmed, via photographic email evidence provided by the PREA Compliance Manager, that the required PREA Audit notices were posted. That evidence confirmed that the notices were posted in various, conspicuous areas throughout each building that comprises the Facility.

Starting on January 25, 2017, this Auditor received an electronic package containing the completed Pre-Audit Questionnaire, agency policies and facility procedures via the PREA Audit System. Upon review of the information and data provided, it became clear that the Agency and Facility had taken several steps toward meeting PREA compliance. A conference call with this Auditor and the Agency Head and the Agency's PREA Compliance Manager (PCM) was conducted on February 8, 2017. This call confirmed that the Facility had made progress toward PREA compliance. A second PREA Audit conference call was held with the Agency Head and PCM on February 15, 2017, confirming that the Facility was ready for the onsite portion of the PREA Audit.

On the first day (February 22, 2017) of the onsite auditing, an introduction meeting was held at approximately 8:30 AM with the Agency Head, Human Resources Director, Facility Superintendent, PREA Coordinator (PC), PREA Compliance Manager, and a representative from the Texas Department of Criminal Justice (TDCJ). It was noted that there were 172 residents (19 male residents and 153 female residents) onsite at the time of the audit. Following this meeting, a tour of the entire Facility was conducted and this Auditor noted the location of the security cameras and the layout of the physical grounds and the various structures. Additionally, this auditor observed notices about this PREA Audit, as well as, some notices regarding the rights of the residents to be free from sexual abuse. During this tour, it was noted that there were "blind spots" but these areas had been noted by Facility staff but not documented. It was also noted that there were no security cameras in the residents' sleeping quarters or areas where they may be changing or performing bodily functions. During the tour this auditor interviewed five (5) female residents, two (2) male residents and five (5) staff.

During this tour, this Auditor observed residents being supervised by the Facility Staff (i.e., monitoring staff). During the onsite the auditing team formally interviewed 18 randomly selected residents, or 10.5% of the residential population. Residents reported being informed of the Facility's Zero-Tolerance Policy related to sexual abuse and sexual harassment and of their right to be free from sexual abuse and sexual harassment, as well as, their right to be free from retaliation for reporting sexual abuse and/or sexual harassment. Five (27.8%) of the residents interviewed indicated that they did not receive PREA Education at the time of their intake and three (3), or 16.7%, stated they couldn't remember getting their

PREA Education. An investigation into these claims revealed that all eight, or 100.0%, of the residents had signed that they received and understood the PREA education within 24-hours of admission. A review of 30 current residents' files (17.4% of current resident population) and 10 former resident files found that all (or 100.0%) did receive PREA information at the time of intake.

As part of the routine work assignment during the onsite portion of this PREA Audit, the auditing team interviewed a total of 17 security staff. Out of the 17 security staff members interviewed, 12 were randomly selected security staff. The security staff interviewed represented staff from all shifts and from all housing units (Horizon and McCaffrey). An additional five (5) security staff were interviewed during the facility tour. In addition, the auditing team interviewed eight (8) specialized staff, to include the Agency Head, PREA Coordinator, Facility Head, HR staff, investigator, staff responsible for retaliation monitoring, intake staff, and staff responsible for screening for risk of victimization and abusiveness. Overall, the staff interviews revealed that all staff were trained in the PREA Standards but only three (3) out of the 12 randomly selected security staff stated that they understood the training. Staff appeared confused about their roles as first responders, they could not produce a Coordinated Response Plan, and several had different answers on how a resident was to report sexual abuse and/or sexual harassment. Only two (2) staff reported being trained in how to search transgender or intersex residents. Staff responsible for conducting intake risk assessments noted that they completed a risk screening but the screening was not objective and did not collect all the information required by PREA. In a review of 40 resident files, all 40 had evidence that PREA Information was provided during intake (defined as the first 72-hour period) and all 40 had PREA Education. However, as the risk screening did not contain all the required PREA items, zero out of 40 were found to have a risk assessment completed within the required 72-hours. As the risk screening did not include questions about previous sexual abuse victimization or sexual abuse perpetration, this auditor could not determine if residents were offered a mental health or medical follow-up.

By the end of the onsite audit, it was found that the Facility's adoption of the intent of the PREA Standards was just beginning. Specifically, policies and procedures did not always reflect the practice. For example, some of the elements of the required definitions prescribed by PREA were not found in the policies and other required components of the PREA Standards could not be found in procedure (e.g., all facility staff noted they have a zero tolerance toward sexual abuse and sexual harassment but some materials only identified sexual abuse, etc.). This resulted in many PREA Standards being identified as "non-compliant." However, the clear majority of these non-compliance's should be easily remedied with minor updates to the Agency's policies, updates to the Facility's procedures, and training of facility staff.

After the onsite portion of this PREA Audit, it was determined that the Facility "Exceeds Standard" on zero PREA Standards; "Meets Standard" on 8 PREA Standards, "Did Not Meet Standard" on 27 PREA Standards while 4 PREA Standards (115.212; 115.235; 115.252; and 115.266) were deemed "Not Applicable."

However, prior to the completion of the Interim Report writing phase the Agency and Facility staff presented additional information, thus it was determined that the Facility "Exceeds Standard" on zero PREA Standards; "Meets Standard" on 18 PREA Standards, "Did Not Meet Standard" on 19 PREA Standards while 4 PREA Standards (115.212; 115.235; 115.252; and 115.266) were deemed "Not Applicable." The Facility entered a Corrective Action Period on April 10, 2017.

The Agency and Facility exited the Corrective Action Period on July 14, 2017 after completing all CAP items. Thus, the Agency and Facility are considered to meet all applicable PREA standards.

Standards
Auditor Overall Determination Definitions
<ul style="list-style-type: none">• Exceeds Standard (Substantially exceeds requirement of standard)• Meets Standard (substantial compliance; complies in all material ways with the stand for the relevant review period)• Does Not Meet Standard (requires corrective actions)
Auditor Discussion Instructions
Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.211	Zero tolerance of sexual abuse and sexual harassment; PREA coordinator
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	<p>REQUIREMENTS: 115.211: This standard has two components (a) An agency shall have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment and outlining the agency’s approach to preventing, detecting, and responding to such conduct and (b) An agency shall employ or designate an upper-level, agency-wide PREA coordinator with sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the following: 1) BVCASA Policy number 610; 2) the Pre-Audit Questionnaire; 3) BVCASA's “Organizational Chart”; and 4) Interviews with staff.</p> <p>OBSERVATIONS: The Agency’s 610 Policy was reviewed and it did note that the Agency had a zero-tolerance policy. However, this Auditor could not find the following: (1) an outline how the agency will implement the agency’s approach to preventing, detecting, and responding to sexual abuse and sexual harassment, (2) definitions of prohibited behaviors regarding sexual abuse and sexual harassment, (3) sanctions for those found to have participated in prohibited behaviors, nor could the auditor find (4) a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents. The agency has employed an upper-level, agency-wide, PREA coordinator with sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in its single facility and this position is listed in the agency’s organizational chart.</p> <p>DETERMINATION: It was determined that the Agency did not meet standard as the Agency did not: (1) outline how it will implement the agency’s approach to preventing, detecting, and responding to sexual abuse and sexual harassment, (2) include definitions of prohibited behaviors regarding sexual abuse and sexual harassment, (3) include sanctions for those found to have participated in prohibited behaviors, and (4) include a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents. During the report writing phase, this Auditor received a revised 610.A policy and it included an outline of how the Agency will implement an approach to preventing, detecting, and responding to sexual abuse and sexual harassment. It also, albeit in a roundabout way, provided a description of the agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents. The definitions in this revised policy still need to be updated to reflect the definitions contained in the Final Rule. During the report writing phase, the Agency was able to: 1) Revise its 610 policy to address the missing elements as noted above; 2) Submit the revised policies and procedures to this auditor; 3) Train staff on the revised policy; and 4) Submit to this Auditor evidence that staff attended and understood the training. Thus, the Agency is determined to meet this standard.</p>

115.212	Contracting with other entities for the confinement of residents
	Auditor Overall Determination: Meets Standard
	<p>Auditor Discussion</p> <p>REQUIREMENTS: 115.212: This standard has three components: (a) A public agency that contracts for the confinement of its inmates with private agencies or other entities, including other government agencies, shall include in any new contract or contract renewal the entity's obligation to adopt and comply with the PREA standards; (b) Any new contract or contract renewal shall provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards; and (c) Only in emergency circumstances in which all reasonable attempts to find a private agency or other entity in compliance with the PREA standards have failed, may the agency enter into a contract with an entity that fails to comply with these standards. In such a case, the public agency shall document its unsuccessful attempts to find an entity in compliance with the standards.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the following: 1) the Pre-Audit Questionnaire and 2) Interview(s) with the Agency and Facility staff responsible for contract monitoring.</p> <p>OBSERVATIONS: Interviews with staff and residents supported the contention that the Agency has zero (0) contracts for confinement services.</p> <p>DETERMINATION: Based on the observations noted above, including staff interviews, it was determined that this PREA Standard is not applicable to this Agency.</p>

115.213	Supervision and monitoring
	<p>Auditor Overall Determination: Meets Standard</p> <p>Auditor Discussion</p> <p>REQUIREMENTS: 115.213: This standard has three components: (a) a staffing plan has been created; (b) deviations from the staffing plan are documented; and (c) the staffing plan is reviewed annually.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the following: 1) BVCASA Policy number 610A; 2) the Pre-Audit Questionnaire; 3) Facility’s Staffing Plan; and 4) Interviews with staff.</p> <p>OBSERVATIONS: The Agency did present a staffing plan but it was in the form of a staff schedule. Interviews with staff noted that the staff to resident ratio during awake hours was 1 to 20 but other staff thought it was 1 to 25 during waking hours. All staff reported that the ratio was 1 to 50 at night. During interviews staff noted that the staff to resident ratio kept residents safe as that was the ratio required by TDJC. During the facility tour, it was found that one staff was supervising 28 residents. When asked about this deviation, it was reported that the facility does not document deviations but that these deviations should not occur.</p> <p>DETERMINATION: The Agency did not develop and document a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against sexual abuse. In calculating adequate staffing levels and determining the need for video monitoring, the Agency did not take into consideration: (1) The physical layout of each facility; (2) The composition of the resident population; (3) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and (4) Any other relevant factors. Further, when the staff plan was not complied with, there is no mechanism for staff to report this deviation, this is a requirement of the PREA Standard. Further, though Agency policy, signed in 2013, noted that staffing plans were to be reviewed, no evidence was presented that these staffing plan reviews occurred. Thus, it was determined that the Facility does not meet this Standard. During the report writing phase, this Auditor received a revised and updated Staffing Plan. This staffing plan addressed all the deficiencies noted during the onsite review with one exception. Add a sentence under “Documenting Deviations to the Staffing Plan” of any reported deviations in the past year. During the report writing phase of this audit the Facility was able to: (1) Train staff on the revised Staff Plan; and (2) Submit to this Auditor evidence that staff attended and understood the training. However, there are still corrective action plan items to complete.</p> <p>CORRECTIVE ACTION PLAN (CAP): The Facility entered the CAP period on April 10, 2017. The Facility will need to: (1) Ensure that the Facility Staffing Plan is followed and that deviations are documented, and (2) DESK AUDIT: The Auditor will wait 6-8 weeks and then will review all Staffing Plan deficiency notices.</p> <p>FINAL DETERMINATION: The Facility exited the CAP period on June 22, 2017 after completing all CAP items. Thus, the facility is determined to meet this standard.</p>

115.215	Limits to cross-gender viewing and searches
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	<p>REQUIREMENTS: 115.215: This standard has six components: (a) The facility shall not conduct cross-gender strip searches or cross-gender visual body cavity searches (meaning a search of the anal or genital opening) except in exigent circumstances or when performed by medical practitioners; (b) The agency shall not conduct cross-gender pat-down searches except in exigent circumstances nor shall Facilities restrict female inmates' access to regularly available programming or other outside opportunities in order to comply with this provision.; (c) The facility shall document all cross-gender strip searches and cross-gender visual body cavity searches, and shall document all cross-gender pat-down searches of female inmates; (d) The facility shall implement policies and procedures that enable inmates to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks. Such policies and procedures shall require staff of the opposite gender to announce their presence when entering an inmate housing unit; (e) The facility shall not search or physically examine a transgender or intersex inmate for the sole purpose of determining the inmate's genital status. If the inmate's genital status is unknown, it may be determined during conversations with the inmate, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner; and (f) The agency shall train security staff in how to conduct cross-gender pat-down searches, and searches of transgender and intersex inmates, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the following: 1) BVCASA Policy number 610B; 2) the Pre-Audit Questionnaire; 3) Interviews with 12 security staff; 4) Video footage hallway outside of the living units, and 4) Interviews with residents (specifically, 11 randomly selected residents).</p> <p>OBSERVATIONS: Interviews with staff and residents confirmed that the Facility does not conduct cross-gender strip searches or cross-gender visual body cavity searches. Further, the Facility is a 'no contact' Facility, meaning the Facility staff never perform a pat-down search. Residents and staff noted that residents could 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. Further, interviews with residents confirmed that staff of the opposite gender always announce their presence when entering resident housing unit. Staff interviews noted that staff would not check a resident to determine their genital status and these findings were corroborated by interviews with residents. However, nine (9) of the 12-facility staff, or 75.0%, during interviews, were uncertain if they attended training on how to conduct cross-gender pat-down searches, and searches of transgender and intersex inmates, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs. Further, Agency and Facility training paperwork could not definitely identify that staff had attended and understood this training. Further, the training curriculum presented did not cover</p>

how to conduct cross-gender pat-down searches, and searches of transgender and intersex inmates, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs. During the report writing phase

DETERMINATION: Based on security staff not being able to recall being trained in how to conduct cross-gender pat-down searches, and searches of transgender and intersex inmates, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs, and since the paperwork provided could not determine if staff attended and understood the training, it was determined that the Facility does not meet this Standard. During the report writing phase the Facility staff were able to: (1) Train security staff on how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs; and (2) Submit to this Auditor evidence that staff attended and understood the updated policies/procedures. Thus, the Facility is determined to meet this Standard.

115.216	Residents with disabilities and residents who are limited English proficient
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	<p>REQUIREMENTS: 115.216: This standard has three components: (a) The agency shall take appropriate steps to ensure that inmates with disabilities (including, for example, inmates who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities), have an equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment; (b) The agency shall take reasonable steps to ensure meaningful access to all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment to inmates who are limited English proficient, including steps to provide interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary; and (c) The agency shall not rely on inmate interpreters, inmate readers, or other types of inmate assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the inmate’s safety, the performance of first-response duties under §115.64, or the investigation of the inmate’s allegations.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the following: 1) the BVCASA Policy number 610C; 2) the Pre-Audit Questionnaire; 3) Interviews with 12 security staff; and 4) Interviews with residents (specifically, 11 randomly selected residents).</p> <p>OBSERVATIONS: BVCASA Policy 610C directly relates to this PREA Standard. However, seven (7) out of 12 staff interviewed could not identify how to access translation services if needed (e.g., some said they would call the police, others stated they would call their supervisor, etc.). Three (3) out of 12 randomly selected security staff, during interviews, noted that they would allow residents to interpret for each other even if it was not an emergency. Thus, staff need additional training related to 115.215(c).</p> <p>DETERMINATION: As staff were unsure how to access translation services that “can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary” it was determined that the Facility does not meet this Standard. During the reporting writing phase the Agency was able to: (1) Update policies and procedures to detail how staff are to access translation services if needed, (2) Update policies and procedures to ensure that staff understand that the agency shall not rely on inmate interpreters, inmate readers, or other types of inmate assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the inmate’s safety, the performance of first-response duties under §115.264, or the investigation of the inmate’s allegations; (3) Train staff on these revised policies and procedures, and (4) Submit to this Auditor evidence that staff attended and understood the updated policies/procedures. Thus, it was determined that the Agency meets this Standard.</p>

115.217	Hiring and promotion decisions
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	<p>REQUIREMENTS: 115.217: This standard has eight components: (a) The agency shall not hire or promote anyone who may have contact with inmates, and shall not enlist the services of any contractor who may have contact with inmates, who— [(1) Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); (2) Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or (3) Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section]; (b) The agency shall consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with inmates; (c) Before hiring new employees who may have contact with inmates, the agency shall: [(1) Perform a criminal background records check; and (2) Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse]; (d) The agency shall also perform a criminal background records check before enlisting the services of any contractor who may have contact with inmates; (e) The agency shall either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with inmates or have in place a system for otherwise capturing such information for current employees; (f) The agency shall ask all applicants and employees who may have contact with inmates directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The agency shall also impose upon employees a continuing affirmative duty to disclose any such misconduct; (g) Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination; and (h) Unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility relied on the following: 1) Pre-Audit Questionnaire; 2) Interviews with agency staff during pre-audit conference calls; 3) BVCASA Policy 610 and 610.D; 4) Review of 24 staff files; and 5) Onsite audit interviews with staff (specifically, BVCASA Human Resource staff).</p> <p>OBSERVATIONS: In a review of 24 staff files, the following was identified: (1) Since 2014, the agency consistently asks employees about the questions related to 115.217(a)[1-3] prior to hiring; (2) The Agency was not considering any incidents of sexual harassment in determining whether to hire or promote anyone; (3) The agency was not making 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; (4) The Agency was not asking employees about misconduct described in 115.215(a) of this Standard during promotions or during employee evaluations; (5) The Agency policy does not impose</p>

upon employees a continuing affirmative duty to disclose any such misconduct; (6) The Agency does state that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination. The Agency does conduct background checks prior to first contact with residents but does not 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. In an interview with HR staff it was noted that the Agency has in place a system to continually track criminal allegations. However, the HR staff could not identify the system, how the system works, how it gets the notification of an arrest or allegation, what crimes are reported, how long this process takes, etc. During the report writing phase of this audit, this Auditor received a revised policy and procedure and updated forms. The updated policies, procedures and forms addressed items, 1, 2, and 4 of this section. Further, conference calls with TDCJ staff noted that all employees and contractors at Land Manor are required to enroll in the State NCIC system that tracks arrests 24 hours a day, 7 days a week. Further, TDCJ noted that TDCJ would notify Land Manor within 1-hour of receipt of this information.

DETERMINATION: It was determined that the agency does not meet this Standard. However, during the report writing phase, Agency staff were able to: (1) Revise policies and procedures to ensure that the Agency 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; (2) Revise forms to ensure that staff understand that material omissions regarding such misconduct (described above) or the provision of materially false information related to PREA 115.217[g] shall be grounds for termination; (3) Revise policies and procedures to ensure that staff have a continuing affirmative duty to disclose any such misconduct, (4) Revise policies and procedures to ensure that unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work, (5) Train affected staff (i.e., HR Staff, Supervisors, etc.) on the new policies and procedures, and (6) Submit to this Auditor evidence that staff received and understood this training.

CORRECTIVE ACTION PLAN (CAP): The facility entered the CAP period on April 10, 2017. The agency/facility shall complete a: (1) **DESK AUDIT:** This Auditor will wait 4-6 weeks and then will request documents related to hiring and promotion of staff and contractors to ensure the changes are institutionalized.

FINAL DETERMINATION: The Facility exited the CAP period on June 22, 2017 after completing all CAP items. Thus, the facility is determined to meet this standard.

115.218	Upgrades to facilities and technology
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	<p>REQUIREMENTS: 115.218: This standard has two components: (a) When designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, the agency shall consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect inmates from sexual abuse; and (b) When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, the agency shall consider how such technology may enhance the agency's ability to protect inmates from sexual abuse.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility relied on the following: 1) Pre-Audit Questionnaire; 2) BVCASA Policy 610; and 3) Onsite audit interviews with staff (specifically, the Facility Director).</p> <p>OBSERVATIONS: The facility acquired the McCaffrey House in 2015. Prior to leasing the building the agency administrators considered the effect of the acquisition and the design of the building upon the agency's ability to protect residents from sexual abuse. This included adding security cameras and adjusting their staffing schedule.</p> <p>DETERMINATION: DETERMINATION: It was determined that the Facility does meet this Standard.</p>

115.221	Evidence protocol and forensic medical examinations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	<p>REQUIREMENTS: 115.221: This standard has eight components: (a) To the extent the agency is responsible for investigating allegations of sexual abuse, the agency shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions; (b) The protocol shall be developmentally appropriate for youth and, as appropriate, shall be adapted from or otherwise based on the most recent edition of the U.S. Department of Justice’s Office on Violence Against Women publication, “A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents,” or similarly comprehensive and authoritative protocols developed after 2011; (c) The agency shall offer all inmates who experience sexual abuse access to forensic medical examinations whether on-site or at an outside facility, without financial cost, where evidentiary or medically appropriate. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The agency shall document its efforts to provide SAFEs or SANEs; (d) The agency shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the agency shall make available to provide these services a qualified staff member from a community-based organization or a qualified agency staff member. Agencies shall document efforts to secure services from rape crisis centers. For this standard, a rape crisis center refers to an entity that provides intervention and related assistance, such as the services specified in 42 U.S.C. 14043g(b)(2)(C), to victims of sexual assault of all ages. The agency may utilize a rape crisis center that is part of a governmental unit as long as the center is not part of the criminal justice system (such as a law enforcement agency) and offers a comparable level of confidentiality as a nongovernmental entity that provides similar victim services; (e) As requested by the victim, the victim advocate, qualified agency staff member, or qualified community-based organization staff member shall accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals; (f) To the extent the agency itself is not responsible for investigating allegations of sexual abuse, the agency shall request that the investigating agency follow the requirements of paragraphs (a) through (e) of this section; (g) The requirements of paragraphs (a) through (f) of this section shall also apply to: [(1) Any State entity outside of the agency that is responsible for investigating allegations of sexual abuse in community confinement facilities; and (2) Any Department of Justice component that is responsible for investigating allegations of sexual abuse in community confinement facilities.] (h) For the purposes of this standard, a qualified agency staff member or a qualified community-based staff member shall be an individual who has been screened for appropriateness to serve in this role and has received education concerning sexual assault and forensic examination issues in general.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) BVCASA Policy 610F, (3) MOU with local hospital, (4) Cooperative working agreement with a local rape crisis center, and (5) Interviews with staff (specifically, the Facility Superintendent and Agency</p>

investigator).

OBSERVATIONS: For investigations, the Agency investigator would handle all non-criminal sexual harassment allegations and for criminal sexual abuse allegations or criminal sexual harassment allegations the Agency would rely on local law enforcement. The agency has contacted the local area hospital and they do provide SANE nursing but does not guarantee one is always available. Interviews noted that staff were not sure what to do if a SANE nurse was unavailable and this issue was not addressed in the MOU. The Agency has contacted the local Rape Crisis Center. The Facility does have an investigator who conducts administrative investigations however the Investigator does not follow a uniform evidence collection process nor has the investigator been trained. As for component (b), there is no documentation that local law enforcement and/or local hospitals whose staff may perform a forensic exam were asked to utilize the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011.

DETERMINATION: It was determined that the Facility does not meet this Standard. However, during the report writing phase Agency and Facility staff were able to: (1) Ensure the agency investigator is trained; (2) Develop a uniform-evidence collection procedure for the Agency investigator to follow; (3) Submit an email to local law enforcement asking them to utilize the appropriate protocol; (4) Submit an email to the local hospital that may be required to conduct a forensic exam and ask that they utilize an appropriate protocol [The protocol shall be developmentally appropriate for youth and, as appropriate, shall be adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011]; and (5) Submit these documents and/or correspondence to this auditor. Thus, it was determined that the Agency meets this Standard.

115.222	Policies to ensure referrals of allegations for investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	<p>REQUIREMENTS: 115.222: This standard has five components: (a) The agency shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment; (b) The agency shall have in place a policy to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. The agency shall publish such policy on its website or, if it does not have one, make the policy available through other means. The agency shall document all such referrals; (c) If a separate entity is responsible for conducting criminal investigations, such publication shall describe the responsibilities of both the agency and the investigating entity; (d) Any State entity responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in community confinement facilities shall have in place a policy governing the conduct of such investigations; (e) Any Department of Justice component responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in community confinement facilities shall have in place a policy governing the conduct of such investigations.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) BVCASA Policy 610F, (3) interviews with staff (specifically, the Facility Superintendent and the Agency investigator), and (4) the search for the Facility website.</p> <p>OBSERVATIONS: The Agency does have a policy related to investigations (610.F). That policy notes that “BVCASA has in place a policy to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations” however this auditor could not find the policy that should be in place.” The agency does have a website and the Agency has made their policies available. The Agency’s investigative policy does not describe the responsibilities of both the Agency and the investigating entity (i.e., local law enforcement and/or DSHS, or TDCJ).</p> <p>DETERMINATION: Since a separate entity is responsible for conducting criminal investigations and because the Agency’s investigation policy does not describe the responsibilities of both the agency and the investigating entity, it is determined that the Facility does not meet this Standard.</p> <p>CORRECTIVE ACTION PLAN (CAP): The Facility entered the CAP period on April 10, 2017. The corrective action items include: (1) Revise the agency policy 610F to ensure that it describes the responsibilities of both the agency and the investigating entity (i.e., local law enforcement and/or DSHS, or TDCJ), (2) Ensure this policy is on the agency’s website or made available via other means, and (3) Submit the revised policy and the method that the agency used to make this information available to this auditor.</p> <p>FINAL DETERMINATION: The Facility exited the CAP period on June 20, 2017 after completing all CAP items. Thus, the facility is determined to meet this standard.</p>



115.231	Employee training
Auditor Overall Determination: Meets Standard	
Auditor Discussion	
<p>REQUIREMENTS: 115.231: This standard has four components: (a) The agency shall train all employees who may have contact with inmates on 10 required topics; (b) Such training shall be tailored to the gender of the inmates at the employee’s facility. The employee shall receive additional training if the employee is reassigned from a facility that houses only male inmates to a facility that houses only female inmates, or vice versa; (c) All current employees who have not received such training shall be trained within one year of the effective date of the PREA standards, and the agency shall provide each employee with refresher training every two years to ensure that all employees know the agency’s current sexual abuse and sexual harassment policies and procedures. In years in which an employee does not receive refresher training, the agency shall provide refresher information on current sexual abuse and sexual harassment policies; and (d) The agency shall document, through employee signature or electronic verification, that employees understand the training they have received.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) BVCASA Policy 610.G, (3) interviews with staff (specifically, the 12 randomly selected security staff), (4) Training forms, (5) Training curricula, and (6) 24 staff files.</p> <p>OBSERVATIONS: Of the 12 random security staff interviewed, nine (9), or 75.0%, noted that they did not receive all the required PREA training. All staff interviews noted they felt they received training that was specific to the “gender of the residents at the Facility.” In a review of staff files, it was apparent that staff received PREA training but in some cases (8 out of 24 files reviewed) this training occurred after the staffs’ first contact with residents. None of the forms used by the Facility documented that staff “understood” the training as the training form used a Likert Scale (scale from Completely Disagree to Completely Agree). In a review of the curriculum, the learning objectives are specific to youth in custody and not to adults at the Facility. The slide notes that “OJJ has a zero-tolerance policy” but nothing is found that states BVCASA has a zero-tolerance policy. Of the 10-required training elements, the curriculum appears to provide for the following: (5) The dynamics of sexual abuse and sexual harassment in confinement; and (8) How to avoid inappropriate relationships with residents. Staff must retake this full training each year.</p> <p>DETERMINATION: As the Agency cannot confirm which staff “understood” the training, as 75.0% of staff could not recall being trained on the required topics. Specifically, question 4 on the Content Assessment form asks: “The information was present at a level I could understand.” The student is asked to mark “completely disagree”; “disagree”; neither agree nor disagree”; “agree”; or “completely agree”. Per interviews with HR, the system allows anyone to receive a certificate if they pass a test, regardless if the student “understood” the training. Further, the curriculum did not specifically address: (1) The agency’s zero-tolerance policy for sexual abuse and sexual harassment; (2) How Facility staff are to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures; (3) Residents’ right to be free from sexual abuse and sexual harassment; (4) The right of residents and employees to be free from</p>	

retaliation for reporting sexual abuse and sexual harassment; (6) The common reactions of sexual abuse and sexual harassment victims; (7) How to detect and respond to signs of threatened and actual sexual abuse; (9) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; and (10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities. Thus, it was determined that the Facility does not meet this Standard. However, during the report writing phase Agency and Facility staff were able to: (1) Revise training forms to ensure that each employee understands the training he/she received; (2) Retrain all staff on the missing elements of the PREA training, specifically the following: (a) Its zero-tolerance policy for sexual abuse and sexual harassment; (b) How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures; (c) Residents' right to be free from sexual abuse and sexual harassment; (d) The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment; (e) The common reactions of sexual abuse and sexual harassment victims; (f) How to detect and respond to signs of threatened and actual sexual abuse; (g) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; and (h) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities; and (3) Revise the Agency training policy to ensure that staff receive the required training at the required time (i.e., prior to first contact with residents).

CORRECTIVE ACTION PLAN (CAP): The Facility entered the Corrective Action Period on April 10, 2017. The corrective action item is: (1) **SITE VISIT:** Once all other CAP items for this Standard are completed, the Auditor will wait 6-8 weeks and revisit the facility and interview newly hired staff to ensure they understand the training.

FINAL DETERMINATION: The Facility exited the CAP period on June 22, 2017 after completing all CAP items. Thus, the facility is determined to meet this standard.

115.232	Volunteer and contractor training
	<p>Auditor Overall Determination: Meets Standard</p> <p>Auditor Discussion</p> <p>REQUIREMENTS: 115.232: This standard has three components: (a) The agency shall ensure that all volunteers and contractors who have contact with inmates have been trained on their responsibilities under the agency’s sexual abuse and sexual harassment prevention, detection, and response policies and procedures; (b) The level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with inmates, but all volunteers and contractors who have contact with inmates shall be notified of the agency’s zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents; and (c) The agency shall maintain documentation confirming that volunteers and contractors understand the training they have received.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) BVCASA Policy 610.G, (3) interviews with staff (specifically, HR staff), (4) Training forms, and (5) volunteer staff files.</p> <p>OBSERVATIONS: The Facility provided evidence that they do not have contractors and this was supported via interviews with staff and residents. However, the facility does have volunteers and interviews noted that volunteers are not provided PREA training.</p> <p>DETERMINATION: As volunteer training was not provided and/or not documented, the facility is determined to not meet standard. However, during the report writing phase Agency and Facility staff were able to: (1) Revise training to ensure that volunteers get basic PREA education (i.e., at a minimum all volunteers and contractors who have contact with residents shall be notified of the agency’s zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents); (2) Ensure that volunteers understand the training they have received; and (3) Revise the Agency training policy to ensure that volunteers receive the required training at the required time (i.e., prior to first contact with residents)</p> <p>CORRECTIVE ACTION PLAN (CAP): The Facility entered the Corrective Action Period on April 10, 2017. The corrective action item is: (1) DESK AUDIT: Once all other CAP items for this Standard are completed, the Auditor will wait 4-6 weeks and request a list of new volunteers to ensure they receive the required PREA training prior to first contact with residents.</p> <p>FINAL DETERMINATION: The Facility exited the CAP period on June 22, 2017 after completing all CAP items. Thus, the facility is determined to meet this standard.</p>

115.233	Resident education
	<p>Auditor Overall Determination: Meets Standard</p> <p>Auditor Discussion</p> <p>REQUIREMENTS: 115.233: This standard has five components: (a) During the intake process, residents shall receive information explaining the agency’s zero-tolerance policy regarding sexual abuse and sexual harassment, how to report incidents or suspicions of sexual abuse or sexual 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; (b) The agency shall provide refresher information whenever a resident is transferred to a different facility; (c) The agency shall provide resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled as well as residents who have limited reading skills; (d) The agency shall maintain documentation of resident participation in these education sessions; and (e) In addition to providing such education, the agency shall ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) BVCASA Policy 610.G, (3) Interviews with residents (specifically, 11 randomly selected residents). (4) Training forms, (5) Training curricula, and (6) A review of 40 resident files.</p> <p>OBSERVATIONS: Interviews with residents and a review of 40 current residents’ files noted that all residents received PREA information and PREA education during the intake process. During the tour of the facility this Auditor could not find that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats. Information on the first floor noted that residents could file a complaint with TDCJ if the issue involved sexual assault but it did not mention sexual harassment. Further, information in the resident handbook only discussed sexual assault and did not include sexual harassment.</p> <p>DETERMINATION: As key information was not continuously and readily available or visible to residents through posters, resident handbooks, or other written formats and some of the material was missing references to sexual harassment, it was determined that the Facility does not meet this Standard. However, during the reporting writing phase Agency and Facility staff were able to ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats.</p> <p>CORRECTIVE ACTION PLAN (CAP): The Facility entered the CAP period on April 10, 2017. There are several CAP items: 1) Update all materials, including the resident handbook, to accurately reflect the inclusion of sexual harassment as part of the Agency’s zero tolerance policy; and 2) Submit evidence of these completed CAP items to the Auditor.</p> <p>FINAL DETERMINATION: The Facility exited the CAP period on April 20, 2017 after completing all CAP items. Thus, the facility is determined to meet this standard.</p>

115.234	Specialized training: Investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	<p>REQUIREMENTS: 115.234: This standard has four components: (a) In addition to the general training provided to all employees pursuant to § 115.231, the agency shall ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings; (b) Specialized training shall include techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral; (c) The agency shall maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations; and (d) Any State entity or Department of Justice component that investigates sexual abuse in juvenile confinement settings shall provide such training to its agents and investigators who conduct such investigations.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) BVCASA Policy 610.G, (3) interviews with Agency investigator, and (4) Training forms.</p> <p>OBSERVATIONS: The Agency could not provide evidence that the investigator had completed the required PREA training. Further, Agency policy 610.G, noted that BVCASA does not conduct sexual abuse investigations but interviews noted that the agency does conduct administrative investigations.</p> <p>DETERMINATION: As the Agency's investigator had never had training related to investigations and the Agency policy stated that the Agency doesn't conduct sexual abuse education when, in fact, interviews noted that administrative sexual abuse investigation might occur, it was determined that the Facility does not meet this Standard. During the report writing phase the Agency staff were able to: 1) Ensure that the agency's investigator(s) receive the required training; 2) Update Agency policy 610.G to note that the Agency might conduct sexual abuse investigations, and 3) Submit evidence to this auditor that the investigators have completed the training. Thus, the Agency is determined to meet this Standard.</p>

115.235	Specialized training: Medical and mental health care
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	<p>REQUIREMENTS: 115.235: This standard has four components: (a) The agency shall ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in [(1) How to detect and assess signs of sexual abuse and sexual harassment; (2) How to preserve physical evidence of sexual abuse; (3) How to respond effectively and professionally to victims of sexual abuse and sexual harassment; and (4) How and to whom to report allegations or suspicions of sexual abuse and sexual harassment]; (b) If medical staff employed by the agency conduct forensic examinations, such medical staff shall receive the appropriate training to conduct such examinations; (c) The agency shall maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere; and (d) Medical and mental health care practitioners shall also receive the training mandated for employees under §115.231 or for contractors and volunteers under §115.232, depending upon the practitioner’s status at the agency.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) BVCASA Policy 610.G, (3) interviews with staff (Facility Superintendent and PREA Coordinator), and (4) Training forms.</p> <p>OBSERVATIONS: Interviews with staff noted that the facility does not have medical or mental health staff at the facility. All mental health needs are provided offsite. Substance Abuse counselors, called LCDC’s, per interviews with the Facility Administration, are not considered mental health staff.</p> <p>DETERMINATION: It was determined that this standard is not applicable.</p>

115.241	Screening for risk of victimization and abusiveness
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	<p>REQUIREMENTS: 115.241: This standard has five components: (a) All residents shall be assessed during an intake screening and upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents; (b) Intake screening shall ordinarily take place within 72 hours of arrival at the facility; (c) Such assessments shall be conducted using an objective screening instrument; (d) The intake screening shall consider, at a minimum, the nine (9) pieces of required information (see standard); (e) The intake screening shall consider prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the agency, in assessing residents for risk of being sexually abusive; (f) Within a set time period, not to exceed 30 days from the resident’s arrival at the facility, the facility will reassess the resident’s risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening; (g) A resident’s risk level shall 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; (h) Residents may not be 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; (i) The agency shall implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident’s detriment by staff or other residents..</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) BVCASA Policy 610.H, (3) interviews with staff (specifically, the Social Services Coordinator and case managers), (4) the PREA Risk Screening Form, and (5) A review of 31 resident files.</p> <p>OBSERVATIONS: The Facility conducts risk screening using a tool called the “Clinical Management for Behavioral Health Services” or called the CMBHS. This tool is not an objective risk assessment tool. The CMBHS does utilize resident intake responses to a variety of questions, but these questions do not include questions related to past victimizations and abusiveness, nor does it inquire about physical build, nor whether the resident/client is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming. The information that is collected is used to help determine an inmate’s risk of depression, suicidal ideation and mental health status. The staff uses the CMBHS, a personal interview, and any other available relevant records to assess each inmate’s risk for self-harm but not for sexual aggressive behavior and vulnerability to sexual victimization. In a review of 40 files, 11 (27.5%), of the residents did not receive this CMBHS screening within 72-hours. Staff interviewed noted that they do not conduct reassessments though BVCASA Policy 610.H notes that “within a set time period, not to exceed 30 days from the resident’s/client’s arrival at the facility, the facility reassesses the resident’s risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening.”</p> <p>DETERMINATION: It was determined that the Facility does not meet this Standard. During the</p>

report writing phase of this audit, this Auditor received a revised screening form. This revised screening form addressed several of the issues identified in the observation section of this report. During the report writing phase Agency and Facility staff were able to: (1) Train staff who are responsible for completing risk assessments that these assessments must be done within 72-hours of admission and then again after 30-days, and (2) Submit evidence that staff responsible for risk assessment attended and understood the training.

CORRECTIVE ACTION PLAN (CAP): The Facility entered the CAP period on April 10, 2017. CAP items include: (1) Revise the current risk assessment form to make it objective or adopt an objective screening form, and (2) **DESK AUDIT:** Once CAP item 1 is completed, this Auditor will wait 4-8 weeks and request copies of the form to ensure that the forms are being utilized.

FINAL DETERMINATION: The Agency exited the corrective action plan period on July 14, 2017 after revising the current risk assessment form to make it objective or adopt an objective screening form, and completing a desk audit to ensure that the revised procedures and form are being used. Thus, the Agency is deemed to meet standard related to 115.241.

115.242	Use of screening information
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	<p>REQUIREMENTS: 115.242: This standard has six components: (a) The agency shall use information from the risk screening required by § 115.241 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; (b) The agency shall make individualized determinations about how to ensure the safety of each resident; (c) In deciding whether to assign a transgender or intersex resident to a facility for male or female residents, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the resident’s health and safety, and whether the placement would present management or security problems; (d) A transgender or intersex resident’s own views with respect to his or her own safety shall be given serious consideration; (e) Transgender and intersex residents shall be given the opportunity to shower separately from other residents; (f) The agency shall not place lesbian, gay, bisexual, transgender, or intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status, unless such placement is in a dedicated facility unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such residents.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) BVCASA Policy 610.G, (3) interviews with residents (specifically, 11 randomly selected residents), and (4) Interviews with staff (specifically the 12 randomly selected security staff and the medical staff and the Social Services Coordinator).</p> <p>OBSERVATIONS: All 12 randomly selected staff interviewed supported the contention that the Facility “never” places a resident in isolation for their own protection against sexual victimization. Further, interviews documented that the risk assessment is not used to make placement and programmatic decisions related to sexual abusiveness or sexual victimization. Staff interviews noted that they have not had any transgender or intersex residents at the facility since 2006. However, staff noted that they would place lesbian, gay, bisexual, transgender, or intersex residents in dedicated facilities, units, or wings solely based on such identification or status if possible. Another staff noted that a resident’s genitalia would dictate which housing unit the residents was placed.</p> <p>DETERMINATION: As the risk assessment tool does not address sexual abusiveness or sexual victimization, the facility cannot use it to make informed decisions. Further, staff noted that they would assign residents to housing units solely based on the residents genital status and/or would place them in a room or ‘hall” with other residents of similar genitalia. It was determined that the Facility does not meet this Standard.</p> <p>CORRECTIVE ACTION PLAN (CAP): The Facility entered into the CAP period on April 10, 2017. There were two CAP items: (1) Once a tool that is compliant with 115.241 is utilized ensure that it is used to make informed decision per this standard, (2) Train staff to ensure that placement of transgender or intersex residents is on a case-by-case basis and that the</p>

residents own views with respect to his or her own safety shall be given serious consideration; (3) Submit evidence to this auditor that the staff responsible for placement decisions have attended and understood the training; and (4) SITE VISIT: Once all CAP items are completed for this corrective action plan, this Auditor conduct a site visit to interview staff to determine how placement decisions are made.

FINAL DETERMINATION: The Facility exited the CAP period on June 22, 2017 after completing all CAP items. Thus, the facility is determined to meet this standard.

115.251	Resident reporting
	<p data-bbox="252 170 896 203">Auditor Overall Determination: Meets Standard</p> <p data-bbox="252 248 523 282">Auditor Discussion</p> <p data-bbox="252 327 1485 786"> REQUIREMENTS: 115.251: This standard has four components: (a) The agency shall provide multiple internal ways for inmates to privately report sexual abuse and sexual harassment, retaliation by other inmates or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents; (b) The agency shall also inform residents of at least one way to report abuse or harassment to a public or private entity or office that is not part of the agency and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request; (c) Staff shall accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports; and (d) The agency shall provide a method for staff to privately report sexual abuse and sexual harassment of inmates. </p> <p data-bbox="252 842 1474 1043"> EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) BVCASA Policy 610.J, (3) Interviews with residents (specifically, 11 randomly selected residents), (4) Interviews with staff, (5) Access to the phone system to make a call to an outside agency; and (6) Review of allegations and investigations of those allegations. </p> <p data-bbox="252 1099 1485 1816"> OBSERVATIONS: Six of the 11 residents could identify multiple internal ways for an inmate to report privately to Facility officials about sexual abuse, sexual harassment, retaliation, and staff neglect or violation of responsibilities that may have contributed to any such incidents. All the interviewed residents noted that they would tell a staff member but four (4) residents noted that they cannot privately report as they must tell a staff member who they are calling. None of the residents could identify a public or private entity or office that is not part of the agency and that can receive and immediately forward residents reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request. Ten of the 12 staff interviewed noted that they must report all verbal reports, anonymous reports, written reports, and reports from third parties regarding allegations of sexual abuse and sexual harassment. However, two staff noted that they would not report 3rd party allegations. Only three staff could report that allegations of sexual abuse and sexual harassment qualified as an emergency grievance, all other staff had differing opinions on this matter. Four staff noted that they would wait until the end of their shift to “document sexual harassment reports” and four staff noted that they inform residents that all grievances must be signed. All security staff interviewed (12 out of 12) noted that they had multiple methods to privately report sexual abuse and sexual harassment of residents. </p> <p data-bbox="252 1872 1477 2152"> DETERMINATION: It was determined that the Facility does not meet this Standard. During the report writing phase of this audit, this Auditor received notification that additional posters were added to the facility. This was documented via photographic evidence. This addressed some of the items observed. During the report writing phase Agency and Facility staff were able to: (1) Revise policy and procedure to ensure that all staff and residents know that they can report sexual abuse and/or sexual harassment via the Grievance procedure and that they can submit these forms anonymously; (2) Retrain staff to ensure that everyone know that they </p>

must accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports; (3) Provide PREA Information to all residents about this phone number and grievance procedure; (4) Provide training to staff on the requirements of this Standard (grievance procedure, anonymous reports, 3rd party reports, and need to immediately document verbal reports); (5) Submit to this Auditor evidence that residents attended and understood the training related to the phone number and grievance procedure; and (6) Submit to this Auditor evidence that staff attended and understood the training related to (grievance procedure, anonymous reports, 3rd party reports, and need to immediately document verbal reports). Thus, the Agency is determined to meet this Standard.

115.252	Exhaustion of administrative remedies
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	<p>REQUIREMENTS: 115.252: This standard has seven components: (a) An agency shall be exempt from this standard if it does not have administrative procedures to address resident grievances regarding sexual abuse; (b)(1) The agency shall not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse; (2) The agency may apply otherwise-applicable time limits on any portion of a grievance that does not allege an incident of sexual abuse; (b)(3) The agency shall not require a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse; (b)(4) Nothing in this section shall restrict the agency's ability to defend against a lawsuit filed by a resident on the ground that the applicable statute of limitations has expired; (c) The agency shall ensure that [(1) A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint, and (2) Such grievance is not referred to a staff member who is the subject of the complaint]; (d)(1) The agency shall issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance; (d)(2) Computation of the 90-day time period shall not include time consumed by inmates in preparing any administrative appeal; (d)(3) The agency may claim an extension of time to respond, of up to 70 days, if the normal time period for response is insufficient to make an appropriate decision. The agency shall notify the resident in writing of any such extension and provide a date by which a decision will be made; (d)(4) At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, the resident may consider the absence of a response to be a denial at that level; (e)(1) Third parties, including fellow inmates, staff members, family members, attorneys, and outside advocates, shall be permitted to assist inmates in filing requests for administrative remedies relating to allegations of sexual abuse, and shall also be permitted to file such requests on behalf of inmates; (e)(2) If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process; (e)(3) If the resident declines to have the request processed on his or her behalf, the agency shall document the resident's decision; (e)(4) A parent or legal guardian of a juvenile shall be allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile. Such a grievance shall not be conditioned upon the juvenile agreeing to have the request filed on his or her behalf; (f)(1) The agency shall establish procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse; (f) (2) After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, the agency shall immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken, shall provide an initial response within 48 hours, and shall issue a final agency decision within 5 calendar days. The initial response and final agency decision shall document the agency's determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance; and (g) The agency may discipline a resident for filing a grievance related to</p>

alleged sexual abuse only where the agency demonstrates that the resident filed the grievance in bad faith.

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

OBSERVATIONS: The agency does not have administrative procedures to address inmate grievances regarding sexual abuse. Inmates', at any time, may proceed to court directly to seek judicial redress for any allegation of sexual abuse without having to file a grievance at the Agency.

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

115.253	Resident access to outside confidential support services
	<p>Auditor Overall Determination: Meets Standard</p> <p>Auditor Discussion</p> <p>REQUIREMENTS: 115.253: This standard has three components: (a) The facility shall provide inmates with access to outside victim advocates for emotional support services related to sexual abuse, by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations, and, for persons detained solely for civil immigration purposes, immigrant services agencies. The facility shall enable reasonable communication between inmates and these organizations and agencies, in as confidential a manner as possible; (b) The facility shall inform inmates, 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; and (c) The agency shall maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide inmates with confidential emotional support services related to sexual abuse. The agency shall maintain copies of agreements or documentation showing attempts to enter into such agreements.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) BVCASA Policy 610.I., (3) Interviews with residents (specifically, 11 randomly selected residents), (4) Interviews with staff (specifically the 12 randomly selected security staff), and (5) Interviews with the PREA Coordinator.</p> <p>OBSERVATIONS: No evidence was found that the Facility provided contact phone numbers and addresses to the local area Rape Crisis Center. A phone interview with the Rape Crisis Center noted that this Facility would provide services to residents from the Facility, if requested. None of the staff and none of the residents knew about the requirement of providing residents with access to outside victim advocates and as noted, there was no evidence that the Facility made accessible mailing addresses and telephone numbers, including toll free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations. Residents and staff noted that the phone calls are not monitored but that phone calls are limited to five minutes. The agency did provide documentation showing that the Agency attempted to enter an MOU with the Rape Crisis Center.</p> <p>DETERMINATION: It was determined that the Facility does not meet this Standard.</p> <p>CORRECTIVE ACTION PLAN (CAP): The Facility entered the CAP period on April 10, 2017. The CAP items are: 1) Provide residents with access to outside victim advocates for emotional support services related to sexual abuse, by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll free hotline numbers where available; 2) Submit photographic evidence of these postings to this Auditor.</p> <p>FINAL DETERMINATION: The Facility exited the CAP period on April 17, 2017 after completing all CAP items. Thus, the facility is determined to meet this standard.</p>

115.254	Third party reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	<p>REQUIREMENTS: 115.254: This standard has one component: (a) The agency shall establish a method to receive third-party reports of sexual abuse and sexual harassment and shall distribute publicly information on how to report sexual abuse and sexual harassment on behalf of a resident.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) BVCASA Policy 610.I., (3) Interviews with residents (specifically, 11 randomly selected residents), (4) Interviews with staff (specifically the 12 randomly selected security staff), and (5) Facility tour where evidence of postings related to this Standard were found.</p> <p>OBSERVATIONS: This Facility has multiple means of receiving third-party reports, including phone calls to the Facility and via email addresses. Further, information about third-party reporting is made available on the Agency's website at http://bvcasa.org/prea/.</p> <p>DETERMINATION: As the Agency has established a method to receive third-party reports of sexual abuse and sexual harassment and has distributed, publicly, via the Agency's website, information on how to report sexual abuse and sexual harassment on behalf of a resident it was determined that the Agency does meet this Standard.</p>

115.261	Staff and agency reporting duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	<p>REQUIREMENTS: 115.261: This standard has five components: (a) The agency shall require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; retaliation against inmates or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation; (b) Apart from reporting to designated supervisors or officials and designated State or local services agencies, staff shall be prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions; (c) Unless otherwise precluded by Federal, State, or local law, medical and mental health practitioners shall be required to report sexual abuse pursuant to paragraph (a) of this section and to inform residents of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services; (d) If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, the agency shall report the allegation to the designated State or local services agency under applicable mandatory reporting laws; and (e) The facility shall report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) BVCASA Policy 610.J, and (3) Interviews with staff (specifically the 12 randomly selected security staff).</p> <p>OBSERVATIONS: Staff interviews supported the contention that the Facility is following this PREA Standard. All staff noted they understood that they were to report all sexual abuse and sexual harassment allegations but two staff noted that they would not report 3rd party allegations.</p> <p>DETERMINATION: As some staff noted that they would not report 3rd party allegations of sexual abuse or sexual harassment it was determined that the Facility does not meet this Standard under subsection (a) of this standard.</p> <p>CORRECTIVE ACTION PLAN (CAP): The Facility entered the CAP period on April 10, 2017. CAP items include: 1) Retrain all staff on 610.J and that staff are to report all allegations of sexual abuse and/or sexual harassment-even 3rd party; and 2) Submit to this Auditor evidence that staff attended and understood this training.</p> <p>FINAL DETERMINATION: The Facility exited the CAP period on April 10, 2017 after completing all CAP items. Thus, the facility is determined to meet this standard.</p>

115.262	Agency protection duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	<p>REQUIREMENTS: 115.262: This standard has one component: (a) When an agency learns that a resident is subject to a substantial risk of imminent sexual abuse, it shall take immediate action to protect the resident.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) BVCASA policy 610.J, (3) Interviews with residents (specifically, 11 randomly selected residents), and (4) Interviews with staff (specifically the 12 randomly selected security staff).</p> <p>OBSERVATIONS: BVCASA Policy 610.J specifically addresses this requirement. During interviews of 12 randomly selected staff, nine noted that they would act immediately to protect an inmate who was subject to a substantial risk of imminent sexual abuse by moving the resident or placing them in line of sight while contacting a supervisor. Three of the staff stated they would not do anything until they talked to a supervisor and one of these three stated that they would tell their supervisor before the end of the shift. Further, all interviewed residents noted that they would “tell staff” if they felt they were at a substantial risk of imminent sexual abuse.</p> <p>DETERMINATION: As 25.0% of the interviewed staff noted that they would not take immediate action to protect the resident, but would instead contact their supervisor and one of the three stated that it might take until the end of their shift to report to the supervisor. Thus, it was determined that the Facility, did not meet this Standard.</p> <p>CORRECTIVE ACTION PLAN (CAP): The Facility entered the CAP period on April 10, 2017. CAP items include: 1) Retrain all staff on that when they learn that a resident is subject to a substantial risk of imminent sexual abuse, the staff member shall take immediate action to protect the resident; and 2) Submit to this Auditor evidence that staff attended and understood this training.</p> <p>FINAL DETERMINATION: The Facility exited the CAP period on April 10, 2017 after completing all CAP items. Thus, the facility is determined to meet this standard.</p>

115.263	Reporting to other confinement facilities
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	<p>REQUIREMENTS: 115.263: This standard has four components: (a) Upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility that received the allegation shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred and shall also notify the appropriate investigative agency; (b) Such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation; (c) The agency shall document that it has provided such notification; and (d) The facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) BVCASA Policy 610.J, (3) Interviews with staff (specifically the 11 randomly selected security staff), (4) Interviews with the Facility Head and (5) Interviews with the Agency Head.</p> <p>OBSERVATIONS: BVCASA Policy 610.J mentions this requirement and the Agency Head noted that she would ensure that the policy was followed.</p> <p>DETERMINATION: It was determined that the Facility does meet this Standard.</p>

115.264	Staff first responder duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	<p>REQUIREMENTS: 115.264: This standard has two components: (a) Upon learning of an allegation that an inmate was sexually abused, the first staff member to respond to the report shall be required to: [(1) Separate the alleged victim and abuser; (2) Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence; and (3) If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and (4) If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating]; and (b) If the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) BVCASA Policy 610.J., (3) Interviews with staff (specifically the 11 randomly selected security staff), and (4) Interviews with the Facility Head.</p> <p>OBSERVATIONS: Only two of the 12 randomly selected security staff understood their role as first responders. The remaining 10 of the staff either did not recall their training and/or were confused as to whether they would ever be a first responder. In interviews with four staff who would not be identified as security staff, these staff could not recall if they were to ask the alleged victim anything.</p> <p>DETERMINATION: It was determined that the Facility does not meet this Standard. However, during the report writing phase of this audit, this Agency and Facility staff were able to: 1) Retrain all security staff on their role as a first responder; 2) Retrain all non-security staff on what is expected if they are a first responder; and 3) Submit to this Auditor evidence that staff attended and understood this training. Thus, the Agency is determined to have meet this Standard.</p>

115.265	Coordinated response
	<p data-bbox="252 170 896 203">Auditor Overall Determination: Meets Standard</p> <p data-bbox="252 248 523 282">Auditor Discussion</p> <p data-bbox="252 327 1477 488">REQUIREMENTS: 115.265: This standard has one component: (a) The facility shall develop a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership.</p> <p data-bbox="252 539 1449 745">EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) BVCASA Policy 610.J, (3) the Facility’s Coordinated Response Plan; (4) Interviews with staff (specifically the 12 randomly selected security staff), (5) Interviews with the Facility Head and (6) Interviews with the Agency Investigator.</p> <p data-bbox="252 797 1437 1088">OBSERVATIONS: The Coordinated Response Plan is not written and could not be found. Further, Agency policy 610.J. noted that “as BVCASA is a substance abuse transitional treatment center, it thus does not have security staff, medical personnel or mental health practitioners. The agency has developed written procedures regarding coordination of staff actions, to include leadership, taken in response to an incident of sexual abuse.” Interviews with staff confirmed that they were unaware of what their role was or even if a Coordinated Response Plan existed.</p> <p data-bbox="252 1140 1331 1173">DETERMINATION: It was determined that the Facility does not meet this Standard.</p> <p data-bbox="252 1225 1477 1561">CORRECTIVE ACTION PLAN (CAP): The Facility entered the CAP period on April 10, 2017. CAP items include: 1) Create a Coordinated Response Plan (CRP); 2) Ensure the CRP Revise the Agency’s Coordinated Response Plan includes the actions of the first responders, medical and mental health practitioners (even if not Agency staff), investigators, facility leadership and other staff/community services as appropriate; 3) Train staff in the revised plan; 4) Submit to this Auditor evidence that staff attended and understood the training related to the CRP; and 5) SITE VISIT: Once all CAP items are completed for this corrective action plan, this Auditor conduct a site visit to interview staff to determine if they understand the CRP.</p> <p data-bbox="252 1612 1347 1691">FINAL DETERMINATION: The Facility exited the CAP period on June 22, 2017 after completing all CAP items. Thus, the facility is determined to meet this standard.</p>

115.266	Preservation of ability to protect residents from contact with abusers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	<p>REQUIREMENTS: 115.266: This standard has two components: (a) Neither the agency nor any other governmental entity responsible for collective bargaining on the agency's behalf shall enter into or renew any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with inmates pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted, and (b) Nothing in this standard shall restrict the entering into or renewal of agreements that govern: [(1) The conduct of the disciplinary process, as long as such agreements are not inconsistent with the provisions of §§ 115.272 and 115.276; or (2) Whether a no-contact assignment that is imposed pending the outcome of an investigation shall be expunged from or retained in the staff member's personnel file following a determination that the allegation of sexual abuse is not substantiated.]</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire and (2) Interview with the Agency Head.</p> <p>OBSERVATIONS: An interview with the BVCASA Agency Head designee noted that the agency does not have a collective bargaining agreement.</p> <p>DETERMINATION: It was determined that this standard is not applicable to this Agency.</p>

115.267	Agency protection against retaliation
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	<p>REQUIREMENTS: 115.267: This standard has six components: (a) The agency shall establish a policy to protect all inmates and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other inmates or staff and shall designate which staff members or departments are charged with monitoring retaliation; (b) The agency shall employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for inmates or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations; (c) For at least 90 days following a report of sexual abuse, the agency shall monitor the conduct or treatment of inmates or staff who reported the sexual abuse and of inmates who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by inmates or staff, and shall act promptly to remedy any such retaliation. Items the agency should monitor include any resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. The agency shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need; (d) In the case of inmates, such monitoring shall also include periodic status checks; (e) If any other individual who cooperates with an investigation expresses a fear of retaliation, the agency shall take appropriate measures to protect that individual against retaliation; and (f) An agency’s obligation to monitor shall terminate if the agency determines that the allegation is unfounded.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) BVCASA Policy 610.J., (3) BVCASA 610, (4) Interviews with staff (specifically the 12 randomly selected security staff), (5) Interviews with residents (specifically, 11 randomly selected residents); and (6) Interviews with specialized staff.</p> <p>OBSERVATIONS: BVCASA Policy 610.J. addresses subsection (a) of this component. Interviews with staff and review of allegations noted that staff do not understand who is designed as a ‘retaliation monitor’ even though BVCASA Policy 610.J. states that “BVCASA protects all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff and designates which staff members or departments are charged with monitoring retaliation.” This Auditor received information from many different staff and each staff identified another staff member as the person responsible for retaliation monitoring.</p> <p>DETERMINATION: It was determined that the Facility does not meet this Standard.</p> <p>CORRECTIVE ACTION PLAN (CAP): The Facility entered the CAP period on April 10, 2017. The three corrective action items include: (1) Revise policy and procedure to specifically identify the staff , by job title, who are responsible for retaliation monitoring; (2) Provide training to effected staff to ensure that they are aware of the requirements for retaliation monitoring, (3) Submit to this auditor signed documents noting that staff received and</p>

understood the revisions to this policy; (4) DESK AUDIT: This Auditor will request a list of staff or residents who are provided retaliation monitoring and (5) SITE VISIT: Once all CAP items are completed for this corrective action plan, this Auditor will conduct a site visit to interview retaliation monitoring staff to determine if they understand their role.

FINAL DETERMINATION: The Facility exited the CAP period on June 22, 2017 after completing all CAP items. Thus, the facility is determined to meet this standard.

115.271	Criminal and administrative agency investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	<p>REQUIREMENTS: 115.271: This standard has 12 components: (a) When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, it shall do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports; (b) Where sexual abuse is alleged, the agency shall use investigators who have received special training in sexual abuse investigations pursuant to § 115.234; (c) Investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator; (d) When the quality of evidence appears to support criminal prosecution, the agency shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution; (e) The credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person's status as resident or staff. No agency shall require a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation; (f) Administrative investigations: [(1) Shall include an effort to determine whether staff actions or failures to act contributed to the abuse; and (2) Shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings]; (g) Criminal investigations shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible; (h) Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution; (i) The agency shall retain all written reports referenced in paragraphs (f) and (g) of this section for as long as the alleged abuser is incarcerated or employed by the agency, plus five years, unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention; (j) The departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation; (k) Any State entity or Department of Justice component that conducts such investigations shall do so pursuant to the above requirements; and (l) When outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) BVCASA Policy 610.K., (3) Interviews with staff (specifically the 12 randomly selected security staff), and (4) Interviews with Agency Investigators.</p> <p>OBSERVATIONS: It was determined, via interviews, that Agency and Facility staff may be asked to conduct sexual abuse and/or sexual harassment investigations. However, the Agency could not provide evidence that the Agency's investigators have been trained. Further, the Agency investigator noted that they would allow a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding</p>

with the investigation of such an allegation. For administrative investigations, it was found that none of the investigations included an effort to determine whether staff actions or failures to act contributed to the abuse; and there was no documentation in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings.

DETERMINATION: It was determined that the Facility does not meet this Standard. However, during the report writing phase of this audit the Agency was able to: 1) Ensure that Agency investigators are trained in investigations; (2) Provide training to investigators to ensure that they fully understand the requirements of this PREA Standard; and (3) Submit to this auditor signed documents noting that staff received and understood this training.

CORRECTIVE ACTION PLAN (CAP): The Facility entered the CAP period on April 10, 2017. The corrective action item is to: (1) **DESK AUDIT:** Six to 8 weeks after the interim report is issued this Auditor will request a list of investigations that have been completed since the onsite audit.

FINAL DETERMINATION: The Facility exited the CAP period on June 22, 2017 after completing all CAP items. Thus, the facility is determined to meet this standard.

115.272	Evidentiary standard for administrative investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	<p>REQUIREMENTS: 115.272: This standard has one component: (a) The agency shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) BVCASA Policy 610.K., and (3) Interviews with investigators.</p> <p>OBSERVATIONS: Investigative staff noted that they do not know what standard is used during interviews though Agency policy 610.K. identifies the standard.</p> <p>DETERMINATION: It was determined that the Facility does not meet this Standard. However, during the report writing phase of this audit the Agency was able to: (1) Ensure that Agency investigators are trained in investigations; (2) Provide training to investigators to ensure that they fully understand the requirements of this PREA Standard; and (3) Submit to this auditor signed documents noting that staff received and understood this training. Thus, the Agency is considered to meet this Standard.</p>

115.273	Reporting to residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	<p>REQUIREMENTS: 115.273: This standard has six components: (a) Following an investigation into a resident's allegation of sexual abuse suffered in an agency facility, the agency shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded; (b) If the agency did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the resident; (c) Following a resident's allegation that a staff member has committed sexual abuse against the resident, the agency shall subsequently inform the resident (unless the agency has determined that the allegation is unfounded) whenever [(1) The staff member is no longer posted within the resident's unit; (2) The staff member is no longer employed at the facility; (3) The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or (4) The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility]; (d) Following a resident's allegation that he or she has been sexually abused by another resident, the agency shall subsequently inform the alleged victim whenever: [(1) The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or (2) The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility]; (e) All such notifications or attempted notifications shall be documented; and (f) An agency's obligation to report under this standard shall terminate if the resident is released from the agency's custody.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) BVCASA Policy 610.K., (3) Interviews with PREA Coordinator, and (4) Interview with Investigator.</p> <p>OBSERVATIONS: Policy 610.K. addresses this Standard. Interviews with staff confirmed that they would follow the policies and procedures outlined in BVCASA 610.K. and noted that they have informed every resident who alleges sexual abuse and/or sexual harassment about the findings of those investigations.</p> <p>DETERMINATION: It was determined that the Facility does meet this Standard.</p>

115.276	Disciplinary sanctions for staff
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	<p>REQUIREMENTS: 115.276: This standard has four components: (a) Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies; (b) Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse; (c) Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) shall be commensurate with the nature and circumstances of the acts committed, the staff member’s disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories; (d) All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) BVCASA Policy 610.L., (3) Interviews with PREA Coordinator, (4) Interview with Investigator, and (5) Interview with Facility Superintendent.</p> <p>OBSERVATIONS: BVCASA Policy 610.L., addresses this Standard. Interviews supported the contention that staff would be disciplined for violating the sexual abuse and/or sexual harassment policies. Further, BVCASA 610.L., specifically states that termination is the presumptive disciplinary sanction.</p> <p>DETERMINATION: It was determined that the Facility does meet this Standard.</p>

115.277	Corrective action for contractors and volunteers
	<p data-bbox="252 170 896 203">Auditor Overall Determination: Meets Standard</p> <p data-bbox="252 248 523 282">Auditor Discussion</p> <p data-bbox="252 327 1485 573">REQUIREMENTS: 115.277: This standard has two components: (a) Any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with inmates and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies; and (b) The facility shall take appropriate remedial measures, and shall consider whether to prohibit further contact with inmates, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.</p> <p data-bbox="252 629 1474 786">EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) BVCASA Policy 610.L., (3) Interviews with PREA Coordinator, (4) Interview with Investigator, and (5) Interview with Facility Superintendent.</p> <p data-bbox="252 842 1474 909">OBSERVATIONS: BVCASA Policy 610.L., complies with this Standard and interviews with staff support the contention that these policies and procedures would be followed.</p> <p data-bbox="252 965 1283 999">DETERMINATION: It was determined that the Facility does meet this Standard.</p>

115.278	Disciplinary sanctions for residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	<p>REQUIREMENTS: 115.278: This standard has seven components: (a) A resident may be subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident sexual abuse; (b) Any disciplinary sanctions shall be commensurate with the nature and circumstances of the abuse committed, the resident’s disciplinary history, and the sanctions imposed for comparable offenses by other inmates with similar histories. In the event a disciplinary sanction results in the isolation of a resident, agencies shall not deny the resident daily large-muscle exercise or access to any legally required educational programming or special education services. Inmates in isolation shall receive daily visits from a medical or mental health care clinician. Inmates shall also have access to other programs and work opportunities to the extent possible; (c) The disciplinary process shall consider whether a resident’s mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed; (d) If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility shall consider whether to offer the offending resident participation in such interventions. The agency may require participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, but not as a condition to access to general programming or education; (e) The agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact; (f) For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation; and (g) An agency may, in its discretion, prohibit all sexual activity between inmates and may discipline inmates for such activity. An agency may not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) BVCASA Policy 610.L., (3) Interviews with PREA Coordinator, (4) Interview with Investigator, and (5) Interview with Facility Superintendent.</p> <p>OBSERVATIONS: It was noted that BVCASA Policy 610.L., that residents will be disciplined per the appropriate disciplinary code or code of conduct. Based on the pre-onsite visit conference calls with the Agency Head and via the Pre-Audit Questionnaire, and via interviews during the onsite, the Facility would not use isolation as the sole sanction for resident-on-resident sexual abuse. Interviews with staff noted that they consider whether a resident’s mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. In addition, interviews confirmed that the facility does not offer therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, thus 115.278(d) is not applicable.</p> <p>DETERMINATION: It was determined that the Facility does meet this Standard.</p>



115.282	<p>Access to emergency medical and mental health services</p> <p>Auditor Overall Determination: Meets Standard</p> <p>Auditor Discussion</p> <p>REQUIREMENTS: 115.282: This standard has four components: (a) Resident victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment; (b) If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, staff first responders shall take preliminary steps to protect the victim pursuant to § 115.262 and shall immediately notify the appropriate medical and mental health practitioners; (c) Resident victims of sexual abuse while incarcerated shall be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate; and (d) Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Interviews with PREA Coordinator, (3) BVCASA Policy 610.M., (4) Interviews with Counselors, and (5) Interview with Facility Superintendent.</p> <p>OBSERVATIONS: The onsite visit interviews noted that resident victims of sexual abuse would be provided with unimpeded access to emergency medical treatment and crisis intervention services. Further, interviews acknowledged that resident victims of sexual abuse while incarcerated shall be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. These findings were supported by Agency Policy 610.M.</p> <p>DETERMINATION: It was determined that the Facility does meet this Standard.</p>
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115.283	Ongoing medical and mental health care for sexual abuse victims and abusers
	<p>Auditor Overall Determination: Meets Standard</p> <p>Auditor Discussion</p> <p>REQUIREMENTS: 115.283: This standard has eight components: (a) The facility shall offer medical and mental health evaluation and, as appropriate, treatment to all inmates who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility; (b) The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody; (c) The facility shall provide such victims with medical and mental health services consistent with the community level of care; (d) Resident victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests; (e) If pregnancy results from conduct specified in paragraph (d) of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services; (f) Resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate; (g) Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident; and (h) The facility shall attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Interviews with PREA Coordinator, (3) BVCASA 610.M., (4) Interviews with Counselors, and (4) Interview with Facility Superintendent.</p> <p>OBSERVATIONS: Interviews confirmed that the Facility does not attempt to ascertain information about a history of sexual abuse (see 115.241). Thus, there are no follow-up services, evaluations or treatment provided. The agency has no policy related to this standard and interviewees were mixed as to what the agency provides and does not provide. As the Facility does not inquire about known resident-on-resident sexual offenders, there is no way for the Facility to attempt to conduct a mental health evaluation within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners.</p> <p>DETERMINATION: It was determined that the Facility does not meet this Standard. However, during the report writing phase of this audit the Agency and Facility staff were able to: (1) Train staff on Agency policy 610.M., (2) Submit to this Auditor evidence that staff attended and understood the training, (3) Provide training to effected staff [e.g., Intake, Risk Assessment staff, counselors, etc.] to ensure that they are aware of the fact that the facility shall attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners, and (4) Submit to this auditor signed documents noting that staff received and understood the revisions to this policy.</p> <p>CORRECTIVE ACTION PLAN (CAP): The Facility entered the CAP period on April 10, 2017.</p>

The following corrective action item was implemented: (1) DESK AUDIT: Four (4) to 6-weeks after submission of the Interim Report, this Auditor will request a list of residents who were identified as being a victim of sexual abuse and/or a resident-on-resident abuser to ensure they received the services specified in this Standard and via BVCASA policy.

FINAL DETERMINATION: The Facility exited the CAP period on June 22, 2017 after completing all CAP items. Thus, the facility is determined to meet this standard.

115.286	Sexual abuse incident reviews
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	<p>REQUIREMENTS: 115.286: This standard has five components: (a) The facility shall conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded; (b) Such review shall ordinarily occur within 30 days of the conclusion of the investigation; (c) The review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners; (d) The review team shall: [(1) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; (2) Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or, gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; (3) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; (4) Assess the adequacy of staffing levels in that area during different shifts; (5) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and (6) Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement and submit such report to the facility head and PREA compliance manager]; (e) The facility shall implement the recommendations for improvement, or shall document its reasons for not doing so.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Interviews with PREA Coordinator, (3) Agency Policy 610.N., (4) Interviews with Counselors, and (5) Interview with Facility Superintendent.</p> <p>OBSERVATIONS: Interviews with staff indicated that the Facility was unaware that a Sexual Abuse Incident Review was needed after every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded and that this review should be done within 30-days of the conclusion of the investigation.</p> <p>DETERMINATION: It was determined that the Facility does not meet this Standard.</p> <p>CORRECTIVE ACTION PLAN (CAP): The Facility entered the CAP period on April 10, 2017. The following corrective action items were implemented: (1) Train staff on Agency Policy 610.N.; (2) Submit to this Auditor evidence that staff attended and understood the training, (3) Provide training to effected staff [e.g., Facility Superintendent, PREA Coordinator, PREA Compliance Manager, etc.] to ensure that they are aware of the fact that the facility shall conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded, (4) Submit to this auditor signed documents noting that staff received and understood the revisions to this policy; and (5) DESK AUDIT: Eight (8) to 10 weeks after completing CAP items 1 and 4 of this CAP, this Auditor will request a list of all</p>

sexual abuse incident reviews (SAIR) that were conducted, including SAIR for sexual abuse allegations that occurred since 2014.

FINAL DETERMINATION: The Facility exited the CAP period on June 22, 2017 after completing all CAP items. Thus, the facility is determined to meet this standard.

115.287	Data collection
	<p data-bbox="252 170 896 203">Auditor Overall Determination: Meets Standard</p> <p data-bbox="252 248 523 282">Auditor Discussion</p> <p data-bbox="252 327 1484 831"> REQUIREMENTS: 115.287: This standard has six components: (a) The agency shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions; (b) The agency shall aggregate the incident-based sexual abuse data at least annually; (c) The incident-based data collected shall include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence (SSV) conducted by the Department of Justice; (d) The agency shall maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews; (e) The agency also shall obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its inmates; and (f) Upon request, the agency shall provide all such data from the previous calendar year to the Department of Justice no later than June 30. </p> <p data-bbox="252 887 1461 1043"> EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) BVCASA Policy 610 N, (3) Interviews with PREA Coordinator, (4) Interviews with staff, and (5) Interview with Facility Superintendent. </p> <p data-bbox="252 1099 1484 1346"> OBSERVATIONS: The Facility could not produce a Standardized instrument that could collect accurate uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. An interview with the PREA Coordinator and Facility Superintendent, indicated that BVCASA does not maintain, does not review, and does not collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. </p> <p data-bbox="252 1402 1334 1435"> DETERMINATION: It was determined that the Facility does not meet this Standard. </p> <p data-bbox="252 1491 1469 1738"> CORRECTIVE ACTION PLAN (CAP): The Facility entered the CAP period on April 10, 2017. The four corrective action items include: (1) Identify and utilize a Standardized instrument consistent with this Standard, (2) Aggregate this data for the past two years (2015 and 2016), (3) Document that this review included a review of data from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews, and (4) Submit these data reviews to the Auditor for review. </p> <p data-bbox="252 1794 1339 1861"> FINAL DETERMINATION: The Facility exited the CAP period on May 10, 2017 after completing all CAP items. Thus, the facility is determined to meet this standard. </p>

115.288	Data review for corrective action
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	<p>REQUIREMENTS: 115.288: This standard has four components: (a) The agency shall 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: [(1) Identifying problem areas; (2) Taking corrective action on an ongoing basis; and (3) Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole]; (b) Such report shall include a comparison of the current year’s data and corrective actions with those from prior years and shall provide an assessment of the agency’s progress in addressing sexual abuse; (c) The agency’s report shall be approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means; and (d) The agency may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility, but must indicate the nature of the material redacted.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) BVCASA Policy 610-N, (3) Interviews with PREA Coordinator, (4) Interviews with staff, and (5) Interview with Facility Superintendent.</p> <p>OBSERVATIONS: No data or annual report was made available to this Auditor.</p> <p>DETERMINATION: It was determined that the Facility does not meet this Standard.</p> <p>CORRECTIVE ACTION PLAN (CAP): The Facility entered the CAP period on April 10, 2017. The six corrective action items include: (1) Once Standard 115.287 is considered to meet Standard the agency shall 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: [(1) Identifying problem areas; (2) Taking corrective action on an ongoing basis, (2) Prepare an annual report of its findings and corrective actions for each facility, as well as the agency as a whole; (3) Ensure that such a report includes a comparison of the current year’s data and corrective actions with those from prior years and shall provide an assessment of the agency’s progress in addressing sexual abuse; (4) Ensure the agency’s report is 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; (5) Ensure that the agency redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility, but must indicate the nature of the material redacted, and (6) Submit a copy of this report to the Auditor.</p> <p>FINAL DETERMINATION: The Facility exited the CAP period on May 10, 2017 after completing all CAP items. Thus, the facility is determined to meet this standard.</p>

115.289	Data storage, publication, and destruction
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	<p>REQUIREMENTS: 115.289: This standard has four components: (a) The agency shall ensure that data collected pursuant to § 115.287 are securely retained; (b) The agency shall make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means; (c) Before making aggregated sexual abuse data publicly available, the agency shall remove all personal identifiers; and (d) The agency shall maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of its initial collection unless Federal, State, or local law requires otherwise.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) BVCASA Policy 610 N, (3) Interviews with PREA Coordinator, (4) Interviews with staff, and (5) Interview with Facility Superintendent.</p> <p>OBSERVATIONS: No data or annual report was made available to this Auditor.</p> <p>DETERMINATION: It was determined that the Facility does not meet this Standard.</p> <p>CORRECTIVE ACTION PLAN (CAP): The Facility entered the CAP period on April 10, 2017. The five corrective action items include: (1) Once Standard 115.288 is considered to meet Standard the agency shall ensure that aggregated sexual abuse data does not contain personal identifiers; (2) Once Standard 115.288 is considered to meet Standard the agency shall ensure that aggregated sexual abuse data is made readily available to the public at least annually through its website or, if it does not have one, through other means (posting at the Facility, etc.), (3) Submit to this Auditor evidence of where data related to this Standard are retained and how the data are retained, and (4) Submit documentation that these data will be maintained for at least 10 years after the date of its initial collection unless Federal, State, or local law requires otherwise.</p> <p>FINAL DETERMINATION: The Facility exited the CAP period on May 10, 2017 after completing all CAP items. Thus, the facility is determined to meet this standard.</p>

115.401	Frequency and scope of audits
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	<p>REQUIREMENTS: 115.401: This standard had six components: (a) During the three-year period starting on August 20, 2013, and during each three-year period thereafter, the agency shall ensure that each facility operated by the agency, or by a private organization on behalf of the agency, is audited at least once; (b) During each one-year period starting on August 20, 2013, the agency shall ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, is audited; (h) The auditor shall have access to, and shall observe, all areas of the audited facilities; (i) The auditor shall be permitted to request and receive copies of any relevant documents (including electronically stored information); (m) The auditor shall be permitted to conduct private interviews with inmates, residents, and detainees; (n) Inmates, residents, and detainees shall be permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) BVCASA Policy 610, (3) Interviews with PREA Coordinator, (4) Interviews with Agency Head, and (5) Interview with Facility Superintendent.</p> <p>OBSERVATIONS: The Agency has scheduled an Audit for 2017, the first for the Agency, but the Agency is preparing to ensure that the Agency is audited for PREA compliance every three years hence. The Auditor had full access to all areas of the facility, could request and receive copies of any relevant documents, was permitted to interviews staff and residents in a private interview format, and the residents noted that they could send private correspondence to this Auditor if needed and postings to this effect were noted in the Facility.</p> <p>DETERMINATION: It was determined that the Facility does meet this Standard.</p>

115.403	Audit contents and findings
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	<p>REQUIREMENTS: 115.403: This standard one applicable component: (f) The agency shall ensure that the auditor’s final report is published on the agency’s website if it has one, or is otherwise made readily available to the public.</p> <p>EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) A link to the Agency’s website; and (2) Interviews with the PREA Coordinator.</p> <p>OBSERVATIONS: The Agency has scheduled an Audit for 2017, the first for the Agency, thus the Agency does not have any PREA Audit reports published. However, interviews with the PREA Coordinator indicated that the 2017 PREA Audit report would be placed on their website as soon as it was received.</p> <p>DETERMINATION: As this is the first PREA Audit for the Facility, it was determined that the standard was not applicable.</p>