

PREA AUDIT REPORT Interim Final
COMMUNITY CONFINEMENT FACILITIES

Date of report: February 18, 2017

Auditor Information			
Auditor name: Melinda Allen			
Address: P.O. Box 703; Braselton, GA 30548			
Email: preaaudit@gmail.com			
Telephone number: 706-449-0003			
Date of facility visit: July 22-26, 2016			
Facility Information			
Facility name: City County Alcohol & Drug Program			
Facility physical address: 725 N. Lacrosse St. Rapid City, SD 57701			
Facility mailing address: <i>(if different from above)</i> Click here to enter text.			
Facility telephone number: 605-394-6128			
The facility is:	Federal	State	<input checked="" type="checkbox"/> County
	Military	Municipal	Private for profit
	Private not for profit		
Facility type:	<input checked="" type="checkbox"/> Community treatment center Halfway house	<input checked="" type="checkbox"/> Community-based confinement facility	
	<input checked="" type="checkbox"/> Alcohol or drug rehabilitation center	<input type="checkbox"/> Mental health facility <input type="checkbox"/> Other	
Name of facility's Chief Executive Officer: Brenda Wood			
Number of staff assigned to the facility in the last 12 months: 47			
Designed facility capacity: 65			
Current population of facility: 42			
Facility security levels resident custody levels: Minimum and Medium			
Age range of the population: 18+			
Name of PREA Compliance Manager: Amber Kemp		Title: Facility Operations Coordinator	
Email address: amberk@pennco.org		Telephone number: 605-394-6128	
Agency Information			
Name of agency: Pennington County Sheriff's Office			
Governing authority or parent agency: <i>(if applicable)</i> Pennington County			
Physical address: 300 Kansas City St; Rapid City, SD 57701			
Mailing address: <i>(if different from above)</i> Click here to enter text.			
Telephone number: 605-394-6113			
Agency Chief Executive Officer			
Name: Kevin Thom		Title: Sheriff	
Email address: Kevin.Thom@pennco.org		Telephone number: 605-394-6113	
Agency-Wide PREA Coordinator			
Name: Melissa Reckling		Title: Staff Assistant IV	
Email address: reckling@pennco.org		Telephone number: 605-394-6116	

AUDIT FINDINGS

NARRATIVE

The site visit for the PREA audit of the City County Alcohol Drug Program (CCADP), Rapid City SD, was conducted on July 22-26, 2016 to determine compliance with the 2003 Prison Rape Elimination Act standards. CCADP operates two facilities at separate locations in Rapid City - one at 725 North Lacrosse Street and the Life Enrichment Center at 3505 Cambell Street. The State of South Dakota Division of Behavioral Health through the Department of Social Services accredits both facilities. On July 22, 2016, I met with PREA Coordinator Melissa Reckling, and PREA Managers Amber Kemp and Clayton McLane at the Life Enrichment Center, where the audit of the facilities began. Following a tour of the facility that included inspection of the building and areas where residents have access, I started resident and staff interviews.

On Monday, July 25, 2016, I met with the PREA Managers and Brenda Wood, the Facility Director. I conducted an in brief where I explained the audit process and expectations. Following a tour of the facility that included inspection of the building and areas where residents have access, I started resident and staff interviews.

With the two facilities combined, I interviewed 10 residents and had informal discussions with two additional residents. The residents were selected from the housing roster. I selected residents from each housing unit and included a mix of residents that had newly arrived and longer-term residents, both male and female. I interviewed six random staff members and sixteen specialized staff members, which included the PREA Coordinator, PREA Managers, the facility HR staff, Supervisors, the Facility Director, Agency Head (designee), and two health care staff. Finally, I completed a review of all pertinent policies, records, and documents.

A debrief was held at the closing of the on site audit with the Facility Director and PREA Managers.

DESCRIPTION OF FACILITY CHARACTERISTICS

The City County Alcohol and Drug Program, located in Rapid City, South Dakota is administered by the Pennington County Sheriff's Office. The mission statement of the department is: "To enhance the quality of life for individuals and families affected by substance abuse and mental health needs."

The CCAPD is a treatment facility designed to house 65 clients. At the time of the audit there were 42 clients on the roster. The facilities have admitted 317 residents in the past 12 months with the average length of stay being four months. The facilities follow an indirect supervision model of management. The facilities have six volunteer/contractors that hold AA and NA meetings. Additional services provided include Treatment Needs Assessments (TNAs), DUI(1) evaluations, 12-hour DUI classes, Corrective Thinking classes, MRT (Moral Recognition Therapy) classes, CBISA (Cognitive Behavioral Interventions for Substance Abuse) classes, Crisis and Early Intervention, Social-Setting Detox, Intensive Outpatient and Residential Treatment, Continued Care Outpatient Services (individual and group counseling), Half-Way House/Transitional Services, Long-Term Specialized Methamphetamine/Opiate Day Treatment, individual and group therapy for Co-Occurring Disorders, and Outreach Case Management Services. The facility has a video monitoring system. Cameras monitor the common areas of both facilities. The cameras are monitored at the tech desks. Video recordings are kept for 14 days. The Showers and toilets have door that prevent residents from being seen by staff while performing these activities. Grievance boxes are located in all living areas. Grievance boxes can be used, as one option, for reporting allegations. The buildings were well maintained, clean and quiet. The CCAPD has 47 staff members.

SUMMARY OF AUDIT FINDINGS

Each of the residents interviewed indicated that they felt safe, and each described the facility as a safe place to be where they did not fear that they would be sexually victimized. All stated that they had received information on the zero tolerance policy, and all knew of at least two options for reporting sexual abuse. All knew about the monitor and their ability to report to that person if they did not want to report to someone inside the facility.

Staffs interviewed were well versed in their responsibilities to prevent, detect, and respond to incidents of sexual abuse and harassment. Staff was familiar with red flags, and had received comprehensive and timely PREA training. Designated staffs were diligent in their duties to protect against retaliation for reporting. Specialized staffs, including supervision, administration, and health-care staff were well versed in PREA requirements and provided ample evidence that facility practices followed policy.

Finally, documentation was complete. Documentation reviewed included, but was not limited to, background and criminal history checks, staff training records, PREA orientation records, policies, documents, and disciplinary and grievance reports. There were no substantiated PREA incidents that occurred during the reporting period.

In summary, the CCADP was found to be non-compliant with several PREA Standards for Community Confinement Facilities and would need to complete corrective action.

Number of standards exceeded:	01
Number of standards met:	39
Number of standards not met:	00
Number of standards not applicable:	02

Standard 115.211 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

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

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

In order to make a determination of compliance with this standard, the PREA Auditor interviewed the PREA Coordinator, PREA Managers, Facility Director and Agency Head. The auditor reviewed policy 140.10, Zero Tolerance Policy adopted 7.1.2016, Policy 140.11, Admission Assessment, and Policy 140.12, PREA Response, PREA Appendix I, the agency organizational charts, training files and observed PREA posters and signage throughout the facility during the review of the facility.

The facility has a zero-tolerance policy, 140.10, which outlines the agencies approach to implementing the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. The policy includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment, sanctions for those found to have participated in prohibited behavior and a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents.

During staff and resident interviews, it was apparent that everyone was aware of PREA and understood that there was a zero tolerance expectation. During the tour, there were several posters attached to the walls giving notice of the zero tolerance expectation.

The agency employs a PREA Coordinator and three PREA Managers. The PREA Coordinator reports to an Administrative Assistant III, who reports to a vacant position of Commander, who then to the Chief Deputy. The PREA Coordinator is responsible for over sight of three PREA Managers in two other facilities. The Pennington County Jail does not have a PREA Manager assigned. It does not appear as though the PREA Coordinator have sufficient authority over the other facilities.

The facility has appointed two PREA Managers for the City County Drug Alcohol Program (CCDAP). The two PREA Managers co-facilitate the facility's efforts in PREA compliance.

The agency employs a PREA Coordinator who is assigned to the Pennington County Jail. This staff member supervises three PREA Managers, which are assigned to two other facilities. The PREA Coordinator acts as the PREA Manager at the jail. While she does seem to have unfettered access to the Chief Deputy to discuss all PREA related issues and concerns. The PREA Coordinator does not have sufficient time to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities.

Corrective Action Recommendation:

In order to meet compliance, the PREA Coordinator should have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities.

Update:

The PREA Coordinator and Compliance Managers have been afforded the time needed to work on PREA compliance.

Standard 115.212 Contracting with other entities for the confinement of residents

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

Non-Applicable

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.

In order to make a determination of compliance with this standard, the PREA Auditor interviewed the PREA Compliance Managers, Facility Director and Agency Head. While this agency has multiple contracts for housing residents for others, they do not house any of their residents or clients out to other facilities.

This standard is non-applicable.

Standard 115.213 Supervision and monitoring

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

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

In order to make a determination of compliance with this standard, the PREA Auditor interviewed the PREA Compliance Manager (PCM), Facility Director and Agency Head. The auditor reviewed policy 140.10, Zero Tolerance Policy adopted 7.1.2016, Policy 140.11, Admission Assessment, and Policy 140.12, PREA Response, PREA Appendix I, the agency organizational charts, training files and observed PREA posters and signage throughout the facility during the review of the facility.

There is a staffing plan in place that discusses the staffing for the facilities, but it does not indicate how they arrived at the number of staff recommended in the staffing plan. The plan does mention the use of video monitoring in order to supplement staffing. The facility has an average of 45 clients in the facility. The staffing plan was based on a population of 88 clients. When faced with a staffing shortage, staff members are called in to work overtime to provide for coverage. The auditor was unable to locate any staffing rosters that indicated that staffing levels were below the daily-recommended numbers.

Corrective Action Recommendations:

The staffing plan must include its best efforts to comply on a regular basis with a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against abuse based on the average daily number of residents housed in the facility. The facility must document each time the staffing plan is not complied with, the facility documents and justifies all deviations from the staffing plan. At least once every year the facility/agency, in collaboration with the PREA Coordinator, must review the staffing plan to see whether adjustments are needed to: (a) the staffing plan, (b) the deployment of monitoring technology, or (c) the allocation of facility/agency resources to commit to the staffing plan to ensure compliance with the staffing plan. This review should be documented annually.

There is a resource available on the PREA Resource Center for developing a Staffing plan compliant with this standard.
<http://www.prearesourcecenter.org/sites/default/files/library/staffingplanfinalwbjalogosubmt.pdf>

Update: 12.29.2016 The facility has developed a staffing plan for the facilities. The auditor has requested that the plan be tweaked a bit to include (1) The physical layout of each lock up [or] facility;
(2) The composition of the client population;
(3) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and
(4) Any other relevant factors.

Update: 1.13.2017 The facility has updated the staffing plan to include the physical layout of the facility, composition of the client population, prevalence of substantiated and unsubstantiated incidents of sexual abuse; and other relevant factors.

Standard 115.215 Limits to cross-gender viewing and searches

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

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

In order to make a determination of compliance with this standard, the PREA Auditor interviewed the PREA Compliance Managers (PCM), a random sample of staff, a random sample of residents, and residents that are limited English proficient. The auditor reviewed policy 140.10, Zero Tolerance Policy, 140.11 PREA Admission Assessment, 140-12, PREA Response to Policy, and the Resident Handbook. During the on site review, I observed the shower and housing unit areas where residents shower, use the restroom and get dressed. These areas provided for individual privacy. I observed staff knock and announce when entering housing unit areas.

The facility does not permit cross gender pat searches under any circumstance. Visual body cavity searches are not conducted at City County Alcohol and Drug Programs. Residents confirmed in interviews that cross gender pat searches are not conducted at either facility. Female residents interviewed confirmed that they have access to programs and other outside opportunities.

§115.215 requires the facility have policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks. The policies and procedures must require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing. The facility does not have a written policy governing this standard. They do have procedures in place to address resident privacy and observations during the on site review indicate that staff of the opposite gender knock and announce prior to entering resident areas.

The facility does not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status. If the resident's genital status is unknown, staff converse with the resident, review medical records, or, if necessary, learn this information as part of a broader medical examination conducted in private by a medical practitioner. The agency does not train security staff in how to conduct pat-down searches of transgender and intersex residents.

Staff interviewed indicated that they are not permitted to conduct cross-gender pat searches.

Corrective Action Recommendations:

Create or revised a PREA policy that enables residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks. The policies and procedures must require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing.

The agency shall train security staff in how to conduct pat-down searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs. Once staff has been trained, a copy of the training curriculum and completion of training are to be provided to the auditor.

Update: The facility has updated the Clients Rights to include the right to shower, perform bodily functions, and change clothing without staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in circumstances when such viewing is incidental due to routine bathroom/room checks. Staff of the opposite gender are required to announce their presence when entering an area with residents of opposite gender who are likely to be showering, performing bodily functions, or changing clothing. The facility has provided updated

training curriculum and proof of completion of the training.

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

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

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

In order to make a determination of compliance with this standard, the PREA Auditor interviewed the PREA Compliance Manager (PCM), a random sample of staff, a random sample of residents and residents that are disabled or limited English proficient. The auditor reviewed policy 140.10, Zero Tolerance Policy adopted 7.1.2016, Policy 140.11, Admission Assessment, and Policy 140.12, PREA Response, and the resident handbook for consideration of compliance. During the on site review, I observed staff members knock and announce their presence when entering the resident's housing areas.

The agency takes appropriate steps to ensure that residents with disabilities (including, for example, residents who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities) have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The facility ensures effective communication with residents who are deaf or hard of hearing, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. Written materials are provided in English, Spanish and in large font for low vision residents. For residents that have intellectual disabilities, limited reading skills, or who are blind, staff will work with on a one on one basis to ensure understanding. In the event the agency does not have a staff interpreter, an interpreter is provided who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. The agency does not rely on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under § 115.264, or the investigation of the resident's allegations. Residents and staff interviewed all confirm that the facility would provide an interpreter that is employed with the Pennington County Sheriff's Office or contracted to ensure understanding.

Standard 115.217 Hiring and promotion decisions

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

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

In order to determine compliance with this standard, I reviewed the agency Global Policies, GP-2-95, Promotional Process, GP 2-23, Background, GP 2-20, Staff Selection and Group Testing, Pennington County Handbook, sampling of staff files which included applications and hiring information, interviewed Administrative HR staff, PREA Coordinator, the Agency Head and Investigators.

Global Policies, Page 30, The Pennington County Sheriff's Office conducts a reasonable investigation into the background of prospective employees, contractors, and volunteers, who, by the nature of the position to be filled, will have access to sensitive information, facilities, computer systems, clients, detainees, residents, procedures, and/or reports. In order to minimize the Sheriff's Office risk exposure, this policy has been established to ensure fair and consistent evaluation.

All candidates for full- and part-time employment with the Sheriff's Office undergo a comprehensive background investigation prior to being made a final offer. Candidates for Seasonal / Temporary employment, contractors, or volunteers are subjected to a limited background investigation. When candidates previously worked for or contracted with another law enforcement agency, the agencies are contacted for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse.

The agency inquires if the applicant has ever had an improper relationship with a client, sexual or otherwise, ever resigned from employment after becoming aware of, being notified of, or during the course of an investigation about your behavior/actions while employed as a law enforcement officer or correctional officer. The agency inquires what was the investigation about and what is the status of that investigation.

The agency does not agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work unless the former employee has signed a waiver permitting the release of the information.

Corrective Action Recommendations:

The hiring and promotion practices should include an inquiry into the consideration of any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any employee or contractor, who may have contact with residents.

Background checks should be completed every five years for contractors, volunteers and employees.

The agency should impose upon employees a continuing affirmative duty to disclose any such misconduct.

The agency should inquire if the applicant has ever been a party to a lawsuit as a result of their actions in the performance of their previous law enforcement, corrections or community confinement job to determine if they have been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section.

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, unless providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.

Update: The agency has instituted a policy of completed a background check every five years for employees and contractors that have contact with residents. They have also instituted the practice in HR to inquire about incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any employee or contractor, who may have contact with inmates. I have reviewed applications and documentation of background checks for consideration of compliance with the corrective action. Global policy 2-23 was revised to address affirmative duty and providing information for applicants to another facility.

Standard 115.218 Upgrades to facilities and technologies

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

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

In order to determine compliance with this standard, I interviewed the Agency Head, Facility Director, and the PREA Managers. A thorough review or tour of the facility was completed during the audit.

The facility acquired a new facility, the Life Enrichment Center (LEC) in 2014. Prior to moving into the facility, the locking mechanisms

were removed from the room doors. Cameras were also added to the counselor's offices. The LEC facility was previously used as a unit for the Juvenile Services Center.

Standard 115.221 Evidence protocol and forensic medical examinations

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

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

The auditor interviewed the PREA Coordinator, PREA Managers, an Investigator with the Sheriff's Office Law Enforcement Division, an Investigator with the CCADP, the Facility Director and the Agency Head (designee) for consideration of compliance with this standard. The auditor also reviewed Policy CC 140-012, Response to Sexual Abuse/Harassment/Misconduct, Law Enforcement Policies revised 5/13/2016 and an MOU with WAVI, Sexual Assault Nurse Examiners and the Pennington County State Attorney's Office.

The agency is responsible for investigating allegations of sexual abuse, and they follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. CCADP staff investigates administrative cases and criminal cases are referred to the Law Enforcement Division within the Sheriff's Office. The Law enforcement Division follows a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. This protocol is detailed in the Law Enforcement Policies document. The protocol is developmentally appropriate for youth and 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. The agency offers victims of sexual abuse access to forensic medical examinations, at an outside facility, without financial cost, where evidentiarily or medically appropriate. Examinations are performed by Sexual Assault Nurse Examiners (SANEs) where possible. If a SANE cannot be made available, other qualified medical practitioners perform the examination. The agency shall document its efforts to provide a SANE. The agency has entered into an MOU with WAVI, Sexual Assault Nurse Examiners and the Pennington County State Attorney's Office to promote the compassionate and just treatment of victims and survivors. Victim advocates services are part of the MOU. If requested by the victim, the victim advocate, or qualified community-based organization staff member will accompany and support the victim through the forensic medical examination process and investigatory interviews providing emotional support, crisis intervention, information, and referrals.

Standard 115.222 Policies to ensure referrals of allegations for investigations

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

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

The auditor interviewed the PREA Coordinator, PREA Managers, an Investigator with the Sheriff's Office Law Enforcement Division, an Investigator with the CCADP, the Facility Director and the Agency Head (designee) for consideration of compliance with this standard. The auditor also reviewed several policies to include CC140-012, Response to Sexual Abuse/Harassment/Misconduct, CC 140-013,

Investigations, Law Enforcement Policies revised 5/13/2016 and an MOU with WAVI, Sexual Assault Nurse Examiners and the Pennington County State Attorney's Office.

The facility ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment (including resident-on-resident sexual abuse or staff sexual misconduct). Policy CC140-013, PREA Investigations Policy does not include who is responsible for conducting criminal investigations.

Corrective Action Recommendations:

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 Web site or, if it does not have one, make the policy available through other means.

Update:

Facility policy has been updated to include referrals to investigations to the Pennington County Sheriff's Office. All CCADP policies are posted online at http://www.pennco.org/index.asp?SEC=7EE38545-BC10-46AF-83E1-681CB18A1436&Type=B_BASIC.

Standard 115.231 Employee training

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

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

In order to make a determination of compliance with this standard, the PREA Auditor interviewed the PREA Coordinator, PREA Managers, Facility Director and a random sample of employees. The auditor reviewed training curriculum, documentation of completed training and acknowledgment of training.

PREA policy indicates that all employees who have contact with offenders are given training on: (a) Its zero-tolerance policy for sexual abuse, sexual harassment and retaliation; (b) How to fulfill their responsibilities regarding prevention, detection, reporting, and response to sexual abuse and sexual harassment; (c) Offenders' right to be free from sexual abuse and sexual harassment; (d) The right of offenders and employees to be free from retaliation for reporting sexual abuse and sexual harassment; (e) The dynamics of sexual abuse and sexual harassment in confinement; (f) The common reactions of sexual abuse and sexual harassment victims; (g) How to detect and respond to signs of threatened and actual sexual abuse; (h) How to avoid inappropriate relationships with offenders; (i) How to communicate effectively and professionally with offenders, including lesbian, gay, bisexual, trans-gender, inter-sex, or gender nonconforming offenders; and (j) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities. The facility provided good examples of training materials used for staff training. I was also provided with copies of sign-in sheets and acknowledgement of training.

Standard 115.232 Volunteer and contractor training

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These

recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

In order to make a determination of compliance with this standard, the PREA Auditor interviewed the PREA Coordinator, PREA Managers, Facility Director and a random sample of contractors/volunteers. The auditor reviewed training curriculum, documentation of completed training and acknowledgment of training.

Contractors and volunteers interviewed acknowledge familiarity with the zero-tolerance policy and how to report an incident of sexual abuse or sexual harassment. There are only six contractors/volunteers assigned to the facility.

Standard 115.233 Resident education

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

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

In order to make a determination of compliance with this standard, the PREA Auditor interviewed the PREA Coordinator, PREA Managers, Facility Director and a random sample of contractors/volunteers. The auditor reviewed training curriculum, documentation of completed training and acknowledgment of training.

The facility provides training to all resident/clients, normally within 48 hours of arrival to the facility. Residents interviewed were familiar with the zero-tolerance policy, how to report an incident and retaliation. All training sessions are documented. Staff indicated that they take additional time to explain the basics to residents that may be struggling or not comprehending the education sessions. Residents that are limited English proficient would have a translator available. The facility also provides for deaf, hard of hearing and low vision resident education. Residents are provided a pamphlet at intake that explains PREA, zero-tolerance and how to report an incident. There are also signs posted throughout the facility.

Standard 115.234 Specialized training: Investigations

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

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

In order to make a determination of compliance with this standard, the PREA Auditor interviewed the PREA Coordinator, PREA Managers, and Facility Investigators. The auditor reviewed training curriculum, documentation of completed training for investigators.

The facility employs two investigators that conduct Administrative investigators at the CCADP. Both of the investigators have received training in conducting a PREA investigation in confinement. Certificates of completion were provided. Interviews with the investigators reveal that the necessary curriculum was covered and the investigators were knowledgeable with interview techniques, proper use of

Miranda and Garrity warnings, sexual abuse evidence collection in confinement and the evidence requirements for referring a case for prosecution.

Interviews with the Criminal Investigator revealed that he has not had a training course in investigating sexual abuse cases in confinement. The criminal investigator works for the Pennington County Sheriff's Office Law Enforcement Division, a part of the same agency as the CCADP.

Corrective Action Recommendation:

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.

Update:

The criminal investigators have completed the sexual abuse in confinement training course through the National Institute of Corrections.

Standard 115.235 Specialized training: Medical and mental health care

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

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

In order to determine compliance with this standard, I reviewed Medical staff training records, training curriculum, and Policy 350.05, Response to Sexual Abuse/Harassment/Misconduct. I also interviewed the PREA Coordinator, PREA Managers, Facility Director, and Medical and Mental Health staff.

The Pennington County Sheriff's Office has a core group of Medical and Mental Health staff that service all three of their facilities. The employees are staff employees, not contractors.

Medical staff interviewed have received several PREA training classes. Medical and mental health staff complete the same PREA training that security staff complete, as well as the PREA Medical and Mental Care Standards training developed by the National Commission on Correctional Health Care (NCCHC) as part of contract deliverables for the National PREA Resource Center (PRC), a cooperative agreement between the National Council on Crime and Delinquency (NCCD) and the Bureau of Justice Assistance (BJA). The facility maintains documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere.

Standard 115.241 Screening for risk of victimization and abusiveness

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These

recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

In order to make a determination of compliance with this standard, the PREA Auditor interviewed the PREA Coordinator, PREA Managers, Staff who perform screening for risk of victimization and a random sample of residents. The auditor reviewed the screening instrument, Policy CC 140-011, PREA Admission Assessment, and documentation of completed assessments. During the on site review I observed how risk screening assessments are stored and discussed the process with staff that complete the assessment.

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. Residents are typically assessed within 48 hours of arrival to the facility. While the screening assessment instrument covers the required criteria, the instrument itself is not objective. An objective instrument is an instrument that is not influenced by personal feelings or opinions in considering and representing facts. One counselor's assessment of a resident's build may be considered small while another counselor may consider the same individual as Medium. Providing structured guidelines help maintain objectivity. Reassessments are conducted within 30 days. Interviews with counselors who conduct the assessments as well as residents confirm that the questions are posed.

The policy requires that a resident's risk level be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness. Residents are not being disciplined for refusing to answer, or for not disclosing complete information in response. The facility has implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents.

Corrective Action Recommendation:

Revise the Screening Instrument to make it a more objective instrument. An objective instrument is an instrument that is not influenced by personal feelings or opinions in considering and representing facts. One counselor's assessment of a resident's build may be considered small while another counselor may consider the same individual as Medium.

Update:

The facility has added an objective chart that directs the assessor in how to determine if the resident is considered small, medium or large in stature. This is done in an objective manner.

Standard 115.242 Use of screening information

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

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

In order to make a determination of compliance with this standard, the PREA Auditor interviewed the PREA Coordinator, PREA Managers, Staff who perform screening for risk of victimization and a random sample of residents. The auditor reviewed the screening instrument, and Policy CC 140-011, PREA Admission Assessment. During the on site review I observed the resident housing areas, showers and commodes. Each shower and commode allowed for individual privacy.

Information gleaned from the risk assessment is used to help determine housing, bed, work, education, and program assignments. The facility considers each resident's assessment to help ensure his or her safety. When 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 considers each individual on a case-by-case basis in order to ensure the resident's health and safety, and whether the placement would present management or security problems. All residents are afforded the opportunity to shower separately from other residents. Lesbian, gay, bisexual, transgender, and intersex residents are not housed in dedicated facilities, units, or wings solely on the basis of such identification or status.

Standard 115.251 Resident reporting

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

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

In order to make a determination of compliance with this standard, the PREA Auditor interviewed the PREA Coordinator, PREA Managers, and a random sample of staff and a random sample of residents. The auditor reviewed Policy CC 140-014, PREA Reporting Policy, the Resident Handbook, Client and staff education curriculum. During the on site review I observed signage posted throughout the facility that detailed how to report an incident. I also called the PREA tip line to verify its operation.

The facility has provided multiple internal ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. Residents may Reports may report by alerting a staff member, having a third party contact the facility or putting a report in the PREA (Prison Rape Elimination Act) box. Additionally, clients may contact one of three outside entities to report sexual abuse. Staff members accept reports made verbally, in writing, anonymously, and from third parties and promptly document any verbal reports. Interviews with staff support the mandatory documentation of all verbal reports. Staff members have a variety of ways to privately report a case of sexual abuse or sexual harassment. Staff may contact one of the hotlines, speak privately with one of the PREA Managers, write an anonymous letter or report an incident to the sheriff's office.

Standard 115.252 Exhaustion of administrative remedies

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

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

In order to make a determination of compliance with this standard, the PREA Auditor interviewed the PREA Coordinator, PREA Managers, and a random sample of staff and a random sample of residents. The auditor reviewed Policy CC 140-014, PREA Reporting Policy, Policy CC 140-13, PREA Investigations, Policy CC140-012 Response to Sexual Harassment/Sexual Abuse, the Client Handbook, Client and staff education curriculum. During the on site review I observed grievance boxes where clients may submit a grievance. Grievance forms are readily available in all housing units.

The facility grievance policy is presented in the Client Handbook. The facility does not impose any time restrictions for submitting a grievance of any kind. They do allow clients to submit a grievance to a staff member that may be the subject of the grievance nor will staff refer the grievance to the offending staff member. There is no informal grievance process in place that clients must follow.

While the facility does not have a policy that specifies that the agency must 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. (2) Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal. (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. (4) At any level of the administrative process, including PREA Audit Report

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, interviews with staff indicate that this protocol would be followed. Best practices would be to include this in policy to ensure that staff are familiar with the time limitations.

The agency has not established a mechanism for submitting an emergency grievance. The agency does not have a policy to discipline a client for filing a PREA complaint in bad faith.

Corrective Action Recommendations:

Include time limitations from 115.252(e) in the policy CC 140-014, PREA Reporting.

115.252 (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. (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 documents 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. A decision should be made and protocol established if the facility is going to discipline a client that files a PREA complaint in bad faith.

Once these time limitations and processes have been established, clients and staff must be educated on the procedures. The education should be documented and curriculum provided to the auditor.

Update:

Facility policy was updated to include procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse. Residents have been trained on the new procedure for filing an emergency grievance.

Standard 115.253 Resident access to outside confidential support services

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

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

In order to make a determination of compliance with this standard, the PREA Auditor interviewed the PREA Coordinator, PREA Managers, a random sample of staff and a random sample of residents. The auditor reviewed the hotline posters, the Client Handbook, and Client education curriculum. During the on site review I observed posters and signage throughout the facility that advised client who they could contact for emotional support related to sexual abuse.

The facility informs residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. It should also be noted that about 90-95% of the clients have their own telephones to use at the facility. The Pennington County Sheriff's Office, the facility's parent agency, has entered into an MOU with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse. The MOU was signed in September 2015.

Standard 115.254 Third-party reporting

- Exceeds Standard (substantially exceeds requirement of standard)

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

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

In order to make a determination of compliance with this standard, the PREA Auditor interviewed the PREA Coordinator, PREA Managers, and a random sample of staff and residents. The auditor reviewed the Client Handbook, and Client education curriculum.

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. The Client Handbook, Page 8, states, "If you are being victimized, or have been victimized, immediately report the incident to any staff member. Staff will protect you from the person who is victimizing you and appropriate referrals Medical and Mental Health services and you have the right to notify law enforcement. Reports may be made by alerting a staff member, having a third party contact the facility or putting a report in the PREA (Prison Rape Elimination Act) box."

While the facility will accept third party reports of sexual abuse of a resident they have not publicly distributed information on how to report resident sexual abuse or sexual harassment on behalf of residents.

Corrective Action Recommendation:

The facility must publicly distribute information on how to report resident sexual abuse or sexual harassment on behalf of residents. This could easily be done by posting on the CCADP website. I would recommend having a page specifically for PREA information. This will be beneficial with other standards as well.

Update: The facility has created a PREA brochure called "Sexual Assault Awareness" that details how a third party can file a report on behalf of a resident. Reporting of Sexual Assault Every report that is made is taken seriously and will be investigated fully. CCADP and LEC have a ZERO tolerance policy for any sexual assaults made or attempted by any Client or staff member in CCADP or LEC. Friends or family members can make reports anonymously at any time by contacting the Directors Office at 1-605-394-6128 Ext.204. For more information you can go to www.prearesourcecenter.org. This information should be made available on the facility website as well.

Standard 115.261 Staff and agency reporting duties

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

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

In order to make a determination of compliance with this standard, the PREA Auditor interviewed the PREA Coordinator, PREA Managers, and a random sample of staff. I reviewed Policy CC 140-014, PREA Reporting Policy, Policy CC 140- 012, Response to Sexual Harassment and Sexual Abuse, Policy CC 140-013, Investigations and staff education curriculum.

All staff are required to report any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Policy 140-014, page 2, section C requires that staff refrain from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions. Interviews with Medical staff confirmed that inform residents of duty to report and the limitation

of confidentiality.

If the alleged victim is 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. South Dakota law requires that State, county or municipal criminal justice employee or law enforcement officer must report.

The facility director indicated that all allegations would be reported to the facility investigators.

Standard 115.262 Agency protection duties

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

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

In order to make a determination of compliance with this standard, the PREA Auditor interviewed the Agency Head (designee), and a random sample of staff. I reviewed Policy CC 140- 012, Response to Sexual Harassment and Sexual Abuse.

Interviews with the Agency Head (designee) and staff indicate that 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. Staff members were quick to state that they would remove the individual from the threat immediately. Many responded that they would personally stay with the individual to prevent anything from happening to them. There were no reports of individuals reporting that they were at risk of imminent sexual abuse in the past 12 months.

Standard 115.263 Reporting to other confinement facilities

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

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

In order to make a determination of compliance with this standard, the PREA Auditor interviewed the Agency Head (designee), and a random sample of staff. I reviewed Policy CC 140- 012, Response to Sexual Harassment and Sexual Abuse.

Policy CC 140-012, page 2, section IV addresses notifying another facility if they learn of a sexual abuse case that happened at the other facility. The facility director or designee would contact the director of the other facility within 72 hours to notify them of the report. The notification would be documented. Likewise, if the facility director received notification that a resident had been abused in their facility (and notified by another facility), the director would ensure that a thorough investigation ensued. The facility director indicated that there had not been any reports provided to other facilities, not had any been received in the past 12 months.

Standard 115.264 Staff first responder duties

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

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

In order to make a determination of compliance with this standard, the PREA Auditor interviewed the Facility Director, PREA Managers and a random sample of staff. I reviewed Policy CC 140- 012, Response to Sexual Harassment and Sexual Abuse.

Facility policy CC 140-12, page 2, section IV provides procedures for responding to a sexual harassment or sexual abuse incident. The policy requires that staff separate and monitor the victim, and to preserve any evidence that may be present. In interviews with random staff, several stated that they would also collect the evidence. Staff that have not been properly trained as investigators should not be collecting evidence.

Non-security staff members interviewed were knowledgeable in advising the victim to not take any actions that could destroy physical evidence and to notify security staff.

Corrective Action Recommendation:

While the policy is in place, staff should be retrained regarding their response requirements so they better understand the requirements. Staff should be able to quickly articulate the steps necessary to protect the victim and preserve the scene. Untrained staff should not be collecting evidence.

Update:

The policy was updated and staff was retrained regarding their response requirements so they better understand the requirements.

Standard 115.265 Coordinated response

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

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

In order to make a determination of compliance with this standard, the PREA Auditor interviewed the Facility Director, PREA Managers Medical and Mental Health staff and a random sample of staff. I reviewed Policy CC 140- 012, Response to Sexual Harassment and Sexual Abuse.

The facility has reported that policy CC 140-012 sections IV, B & C serve as the 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. The policy provides detailed response for staff first responders, medical and mental health practitioners, investigators, and facility leadership. Staff members interviewed were familiar with the plan and knowledgeable with their required duties.

Standard 115.266 Preservation of ability to protect residents from contact with abusers

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

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.

In order to determine compliance with this standard, I interviewed the Jail Commander, and the Agency Head (designee) as well as the PREA coordinator.

The facility, nor any other governmental entity, has not participated in any form of collective bargaining or other agreements.

This standard is non-applicable.

Standard 115.267 Agency protection against retaliation

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

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

In order to make a determination of compliance with this standard, the PREA Auditor interviewed the Facility Director, PREA Managers Medical and Mental Health staff and a random sample of staff. I reviewed Policy CC 140- 014, PREA Reporting.

Policy CC 140- 014, PREA Reporting provides for several ways for victims to report retaliation, the policy does not establish a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff, or designate which staff members or departments are charged with monitoring retaliation. This provision of the standard requires a policy.

The PREA Managers indicated that all staff would be responsible for monitoring retaliation and reporting concerns to the PREA Managers. The facility must designate which staff member(s) or departments are charged with monitoring retaliation. The duties of the retaliation monitor will include monitoring the conduct and treatment of residents or staff who reported the sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff. The monitor should act promptly to remedy any retaliation. The retaliation monitor should monitor any resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff for a minimum of 90 days. The agency shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need. Interviews with the PREA Managers indicated that monitoring would be continued throughout the individual's stay at the facility. No cases have been reported, thus no monitoring has occurred. The PREA Manager indicated that there would be periodic checks conducted. They would check on the individual daily for the first few days, then every few days for the duration of their stay. The facility would protect witnesses as well.

Corrective Action Recommendation:

Update policy to include standard § 115.67 Agency protections against retaliation. (a) The agency shall establish a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff, and shall designate which staff members or departments are charged with monitoring retaliation.

Update: The Zero Tolerance policy was updated to include protections against retaliation.

Standard 115.271 Criminal and administrative agency investigations

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

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

In order to determine compliance with this standard, I reviewed Policy 140-013, Investigations. I interviewed an Administrative Investigator and a Criminal Investigator, the Facility Director, PREA coordinator and the Agency Head (designee).

CCAPD staff members are charged with completing all administrative investigations and the Law Enforcement Division of the Pennington County Sheriff's Office is responsible for conducting criminal investigations, unless the case is egregious enough and involves a staff member. In this case, an outside entity would be contacted to conduct the investigation in order to maintain transparency.

The facility has a policy, 140-013, Investigations, that the facility will investigate any allegation of sexual abuse/harassment/misconduct in support of Prison Rape Elimination Act of 2003, National PREA Standards, 28 C.F.R. Part 115. This policy mandates that they use administrative investigators who have received special training in sexual abuse investigations pursuant to § 115.34. During interviews with the criminal Investigators I learned that the investigator has not received any specialized training on conducting sex abuse investigations in a confinement setting.

Investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data. They interview alleged victims, suspected perpetrators, and witnesses; and review prior complaints and reports of sexual abuse involving the suspected perpetrator.

The criminal investigator interviewed indicated that he does not consult with prosecutors prior to conducting compelled interviews.

Investigators never require resident victims to submit to a polygraph or other truth-telling device during the investigative process when investigating PREA incidents.

Policy 140-013, Page 2, E, 1-4 details that the administrative investigation will include an effort to determine whether staff actions or failures to act contributed to the abuse and administrative investigators will document in their written reports a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings.

Criminal investigations document in their written reports a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible.

Policy 140-013, Page 1, III, A I requires that any allegation determined criminal in nature would be immediately referred to law enforcement, once law enforcement has completed their investigation, they would refer the case to the prosecutor.

Policy 140-013, Page 2, III, G refers to the retention of written reports. All written reports are retained as long as alleged abuser is incarcerated or employed by the agency, plus five years.

Investigators interviewed confirmed that investigations would continue even if the alleged abuser or victim departed from the employment or control of the facility or agency.

Corrective Action Recommendation:

All investigators that investigate PREA related incidents shall received special training in sexual abuse investigations pursuant to § 115.34.

The agency shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution.

Update:

The criminal investigators have completed the NIC's training on sexual abuse in confinement in order to satisfy this standard. Compelled interviews are now conducted after consulting with prosecutors.

Standard 115.272 Evidentiary standard for administrative investigations

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

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

In order to determine compliance with this standard, I reviewed Policy 350.04, Investigation. I interviewed two Investigative staff, the jail commander and the PREA coordinator.

Policy 140.013, Page 2, D, I. requires that an investigator will use the "preponderance of evidence" in determining whether allegations of sexual abuse/harassment/misconduct are substantiated. Both investigators interviewed indicated that they would use the "preponderance of the evidence" standard when conducting investigations.

Standard 115.273 Reporting to residents

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

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

In order to determine compliance with this standard, I reviewed Policy 140-010, Zero Tolerance. I interviewed two Investigative staff, the PREA coordinator and the PREA Managers. There were no reports to review during the onsite review.

Both investigators interviewed indicated that residents would be notified of the status of their cases, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the agency. There were no

sexual abuse investigations to review for compliance.

CCAPD staff members conduct administrative investigations and the Pennington County Sheriff's Office conducts criminal investigations. The Facility Director, PREA Coordinator and PPREA Managers would remain informed of the status of the investigation.

Investigators interviewed stated that they would inform the resident when a staff member is no longer posted within the resident's unit, the staff member is no longer employed at the facility, the agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or the agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility when the investigation involves a staff member.

Similarly, if the alleged perpetrator is another resident, the agency would inform the alleged victim whenever the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or the alleged abuser has been convicted on a charge related to sexual abuse within the facility. These notifications or attempted notifications would be documented.

Standard 115.276 Disciplinary sanctions for staff

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

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

In order to determine compliance with this standard, I reviewed the Global Policies of the agency. I interviewed the Facility Director, Agency Head (designee) Investigators, and the PREA coordinator. There were no cases to review during the on site tour.

Global Policies, Page 97, A, 8 states that where evidence is established to sustain a violation of this policy, immediate disciplinary action shall be taken against the offending employee, up to and including termination from employment with this agency. However, Global Policies, Page 98, 3, A state All Sheriff's Office employees are empowered with authority by their government to protect the public from criminal activity. When an employee abuses this authority for sexual purposes, and violates another person, the employee not only commits a crime against the victim, but also damages the credibility and trust of the entire law enforcement community with the public. The purpose of this policy is to caution all employees that any violation of the public trust involving sexual misconduct will result in severe consequences including prosecution to the fullest extent possible. Termination should be the presumptive disciplinary sanction for staff who have engaged in sexual abuse.

Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories.

The facility has a policy, CC 140-015, Discipline, that staff who engages in behavior deemed criminal would be terminated and reported to law enforcement. Terminated staff are reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation are reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

Standard 115.277 Corrective action for contractors and volunteers

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

- Does Not Meet Standard (requires corrective action)

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

In order to determine compliance with this standard, I reviewed Policy 140-10, Zero Tolerance. I interviewed the Facility Director, the PREA Managers and the PREA coordinator. During the onsite review, I reviewed contractor and volunteer training records.

Facility policy 140-015 requires that all volunteers and contractors who engage in sexual abuse be reported to law enforcement agencies (unless the activity was clearly not criminal) and to relevant licensing bodies. The facility would take appropriate remedial measures, and considers whether to prohibit further contact with residents, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer. Interviews indicate that contractors and volunteers accused of abusing a resident would be fully investigated, and if criminal in nature, the agency would aggressively prosecute and ban the contractor/volunteer from the facility.

There were no reports of contractors or volunteers engaging in sexual abuse or sexual harassment. Interviews with administrative staff were consistent with the policy language.

Standard 115.278 Disciplinary sanctions for residents

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

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

In order to determine compliance with this standard, I reviewed Policy 140-015, the Resident Handbook; I interviewed the Facility Director, Medical and Mental Health Staff, the PREA coordinator and the PREA Managers. During the onsite review, I reviewed disciplinary records.

Policy 140-015, Page 3, A. states that disciplinary sanctions will be proportionate to the nature and circumstances of the violation, the individual's discipline history and sanctions imposed for similar incidents. This applies to both clients and staff. Clients will be disciplined for sexual contact with clients upon finding that the client did not provide consent. Residents and/or staff who are found guilty of violating this policy will be subject to disciplinary sanctions and criminal prosecution if determined criminal in nature. There were no cases to review in the previous 12 months. Sanctions imposed on residents are commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories.

Mental Health staff indicated that they do not therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, but they would offer coping skills for resident abusers or perpetrators but do not offer any focused therapy for perpetrators for their sexual abuse issues in an effort to address and correct underlying reasons or motivations for the abuse. Residents would be disciplined if they have sexual contact with staff only upon a finding that the staff member did not consent to such contact. The facility prohibits all sexual activity between residents. However, the facility does not deem consensual activity to constitute sexual abuse.

Standard 115.282 Access to emergency medical and mental health services

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

relevant review period)

- Does Not Meet Standard (requires corrective action)

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

In order to determine compliance with this standard, I reviewed Policy 140-010, Zero Tolerance. I interviewed Medical Staff, the Facility Director, and the PREA coordinator. During the on site review, I had informal discussions with additional medical staff.

Medical staff confirmed in interviews that resident victims of sexual abuse would receive timely, medical and mental health practitioners according to their professional judgment determine unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which. Medical staff at CCADP would facilitate the resident going to the Rapid City Hospital to see a SANE, and WAVI for advocacy. An MOU was signed by the Pennington County Sheriff's Office in September 2015 in conjunction to form a Sexual Assault Task Force that comprised of community resources to provide a victim centered approach to responding to a sexual abuse case. If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, security staff first responders take preliminary steps to protect the victim pursuant to § 115.262 and immediately notify the medical and mental health staff. Medical staff indicated that resident victims of sexual abuse would 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. Medical staff indicated that these services would be provided by the Rapid City Hospital as part of the MOU. Treatment services are provided to resident victims of sexual abuse without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

Standard 115.283 Ongoing medical and mental health care for sexual abuse victims and abusers

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

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

In order to determine compliance with this standard, I reviewed Policy 140-012, PREA Response to Sexual Harassment/Abuse/Misconduct. I interviewed Medical and Mental Health Staff, the Facility Director, the PREA Managers and the PREA coordinator. During the on site review, I had informal discussions with additional medical staff. There were no residents present that had reported an incident of sexual abuse to interview.

Policy 140-012, Response to Sexual Harassment/Abuse/Misconduct, Page 2, section E states that clients who are victims of sexual abuse occurring within the facility are provided appropriate medical treatment and counseling. Page 3, Section C, 1 states, "Medical and Mental Health offers services as appropriate; to include but not limited to: follow up medical care, treatment plans, and referrals if necessary." Medical and Mental Health staff confirmed that the services are consistent with community level of care. Medical staff indicated that if pregnancy results from a sexual abuse case in the facility, the victim would receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services. Additionally, resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate. All treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The facility would 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 if the individual remained in the facility. However, the facility would most likely remove the individual from the program.

Standard 115.286 Sexual abuse incident reviews

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

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

In order to determine compliance with this standard, I reviewed Policy 140-010, Zero Tolerance. I interviewed the Facility Director, the PREA Managers and the PREA coordinator.

Policy 140-010, Page 3, K, states, "The facility will conduct an incident review at the conclusion of every sexual abuse investigation unless the incident is determined to be unfounded." There have not been a reports made, therefore there were no reports to review. PREA Managers indicated that a thorough incident review would occur within 30 days of the closure of the investigation. However, interviews revealed that the Incident Review Team has not yet been established. I discussed the requirements of the Incident Review Team with the staff.

Corrective Action Recommendation:

Form a review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners. 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 Coordinator.

The facility shall implement the recommendations for improvement, or shall document its reasons for not doing so.

I would recommend creating a template for the Incident Review Team (IRT) to follow and to use as proof documentation that the IRT met and discussed the required items.

Update: The facility has incorporated incident reviews for all PREA related incidents. The facility will conduct an incident review at the conclusion of every sexual abuse investigation not to exceed 30 days, unless the incident is determined to be unfounded. The incident review team will include facility Director, Operations coordinator, Clinical supervisors, Counseling staff, Tech supervisors, Medical staff, PREA/ Law enforcement investigators and PREA managers. The facility will implement the recommendations from the incident review team or document the reasons for not doing so. A template was designed to follow for each PREA case in the future should there be a need to review a case.

Standard 115.287 Data collection

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance

determination, the auditor’s analysis and reasoning, and the auditor’s conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

In order to determine compliance with this standard, I reviewed Policy 140-010, Zero Tolerance. I interviewed the Facility Director, the PREA Managers and the PREA coordinator.

CCAPD does track the number of PREA incidents, but has not yet created an annual report.

Corrective Action Recommendation:

The agency shall aggregate the incident-based sexual abuse data at least annually. The incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice. 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.

Update:

The facility has completed the Survey of Sexual Violence. The facility maintains, reviews and collects data needed from all available incident-based documents, reports, investigative files and sexual abuse incident reviews.

Standard 115.288 Data review for corrective action

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

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

The facility has not yet created an annual report of PREA Incidents. An annual report should be generated each year, even if there are no incidents to report.

Corrective Action Recommendation:

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 by: (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. The 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 and be approved by the agency head and made readily available to the public through its website. The agency should indicate the nature-redacted material where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility.

Update: The facility has generated an annual report. The report is publicly available. The report does not contain any personal identifiers. The report will be retained for a period of ten years. The report was posted on the agency website and can be found at http://www.pennco.org/index.asp?SEC=E31CC384-2EF3-4A56-BF7E-DF7FCAF80037&Type=B_BASIC

Standard 115.289 Data storage, publication, and destruction

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

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

The facility has not generated any annual PREA reports to date.

Corrective Action Recommendations:

The agency shall ensure that data collected pursuant to § 115.287 are securely retained. 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. Before making aggregated sexual abuse data publicly available, the agency shall remove all personal identifiers. The agency shall maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection unless Federal, State, or local law requires otherwise.

Update: The facility has generated an annual report. The report is publicly available. The report does not contain any personal identifiers. The report will be retained for a period of ten years.

Standard 115.401 Frequency and Scope of Audit

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

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

The agency operates three facilities, the Pennington County Jail, the City County Alcohol and Drug Program and the Western South Dakota Juvenile Services Center. This was the first audit for this facility. All three facilities were being audited in August 2016. The agency did not meet this standard for this audit cycle. In the future, 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. While conducting this audit, the auditor was given access to, and the ability to observe, all areas of the audited facility. The auditor was permitted to request and receive copies of any relevant documents (including electronically stored information) and to conduct private interviews with inmates, residents, and detainees. Inmates were permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel.

Corrective Action Recommended:

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 during each one-year cycle that commenced on August 20, 2013. The next audit cycle will start on August 19, 2016. The agency shall ensure that at least one third (one) facility is audited between August 20, 2016 and August 19, 2017.

Update:

Guidance from the PREA Resource Center website indicates the following, "The standards require generally that an agency must have “at least one-third” of its facilities audited during each one-year period, which began on August 20, 2013; and that all facilities must be

audited by the conclusion of each three-year period, which began on the same date. See 28 C.F.R. § 115.401(a)&(b). Compliance with the audit timeline is evaluated both on a year-to-year basis and at the conclusion of the three-year audit cycle. Failure to comply with the audit timeline during the initial year of an audit cycle does not preclude compliance during years two and three of an audit cycle. Similarly, failure to comply with the audit timeline during the first two years of an audit cycle does not preclude compliance during the final year of each audit cycle. It is important to note that, for purposes of complying with standard 115.401(a) (requiring audits of each facility during the three-year audit cycle), agencies must ensure that each facility is audited at least once by August 19, 2016, and during every three-year anniversary thereafter."

Standard 115.403 Audit Content and Findings

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

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

I certify that no conflict of interest exists with respect to my ability to conduct an audit of the agency under review and that the contents of this report are accurate to the best of my ability. I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template. I have found that the agency wide policies are compliant with the PREA Standards.

AUDITOR CERTIFICATION

I certify that:

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



February 18, 2017

Auditor Signature

Date