**PREA AUDIT REPORT ☐ Interim ☒ Final**

**COMMUNITY CONFINEMENT FACILITIES**

**Date of report:** September 1, 2017

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|---|---|---|---|
| **Auditor Information** | | | |
| **Auditor name:** Kayleen Murray | | | |
| **Address:** P.O. Box 2400 Wintersville, Ohio 43953 | | | |
| **Email:** kmurray.prea@yahoo.com | | | |
| **Telephone number:** 740-317-6630 | | | |
| **Date of facility visit:** May 15-16, 2017 | | | |
| **Facility Information** | | | |
| **Facility name:** MonDay Community Base Correction Facility | | | |
| **Facility physical address:** 1951 Gettysburg Avenue, Dayton, Ohio 45417 | | | |
| **Facility mailing address:** *(if different from above)* Click here to enter text. | | | |
| **Facility telephone number:** 937-496-7300 | | | |
| **The facility is:** | ☐ Federal | ☒ State | ☐ County |
| | ☐ Military | ☐ Municipal | ☐ Private for profit |
| | ☐ Private not for profit | | |
| **Facility type:** | ☐ Community treatment center<br>☐ Halfway house<br>☐ Alcohol or drug rehabilitation center | ☒ Community-based confinement facility<br>☐ Mental health facility<br>☐ Other | |
| **Name of facility's Chief Executive Officer:** Mike Flannery | | | |
| **Number of staff assigned to the facility in the last 12 months:** 115 | | | |
| **Designed facility capacity:** 298 (202 male/96 female) | | | |
| **Current population of facility:** 276 | | | |
| **Facility security levels/inmate custody levels:** minimum | | | |
| **Age range of the population:** 18 and older | | | |
| **Name of PREA Compliance Manager:** Ruby Galpin | | **Title:** Accreditation Manager | |
| **Email address:** rgalpin@mondaycbcf.com | | **Telephone number:** 937-496-3008 | |
| **Agency Information** | | | |
| **Name of agency:** Click here to enter text. | | | |
| **Governing authority or parent agency:** *(if applicable)* Ohio Department of Rehabilitation and Correction | | | |
| **Physical address:** 770 West Broad Street, Columbus, Ohio 43222 | | | |
| **Mailing address:** *(if different from above)* | | | |
| **Telephone number:** 614-387-0588 | | | |
| **Agency Chief Executive Officer** | | | |
| **Name:** Gary Mohr | | **Title:** Director | |
| **Email address:** gary.mohr@odrc.state.oh.us | | **Telephone number:** 614-387-0588 | |
| **Agency-Wide PREA Coordinator** | | | |
| **Name:** Cynthia Ali | | **Title:** Program Administrator | |
| **Email address:** Cynthia.ali@odrc.state.oh.us | | **Telephone number:** 614-728-1494 | |

## AUDIT FINDINGS

### NARRATIVE

The PREA audit for MonDay Community Based Correctional Facility was conducted on May 15-16, 2017 in Dayton, Ohio. MonDay opened in March of 1978 and continues to provide a secure treatment environment for male and female felony offenders. The facility provided the auditor with a flash drive that contained relevant documentation to indicate compliance with the PREA standards. The pre-audit questionnaire, a list of community partners and their phone numbers, floor plans, and MOU's were included in the documentation. The auditor had ample time to review the documentation before the onsite audit.

During the audit the auditor toured the facility and conducted formal staff and resident interviews. During the tour it was noted that multiple PREA audit notices were posted in both resident and staff areas including the main entrance where visitors to the facility could also see the notices. The notices included the name and address (mailing and email) of the auditor and the date in which the notice was posted. The auditor received no contact from residents or staff prior to the audit. Also posted were notices as to how anyone could report a PREA allegation. The notices included the names, numbers, and addresses of internal and external agencies they can make an anonymous report, and that anyone can report a PREA allegation to any staff member at any time verbally or in writing.

Ten male residents from the three housing units were interviewed including one resident that filed a sexual harassment allegation against a fellow resident. Eight female residents were also interviewed. Residents were asked about their experience with PREA education, allegation reporting, communication with staff, safety, restrooms, knock and announcements, grievance procedures, pat downs, PREA brochures/postings, and the zero tolerance policy. The resident who filed an allegation was also asked about the reporting process, facility protection from retaliation, and notification of the allegation outcome.

The auditor also interviewed specialized staff. This staff includes: Executive Director, PREA Coordinator, Compliance Specialist, Clinical Manager, Investigators, Human Resource personnel, and Emotional Support personnel. The auditor reviewed Miami Valley Hospitals website for information on their SANE program. The auditor was able to verify services through the organization's website. The facility does have a MOU with the Montgomery County Prosecutor's Office Victim Witness Division to provide emotional supportive services; however, can only provide residents with the agency's contact information due to the limits placed on the agency by PREA standard 115.221 D. The facility will use staff trained emotional support personnel to accompany and support the victim through the forensic medical examination process and investigatory interviews. Random staff were questioned about PREA training, how to report, to whom to report, filing reports, investigations, conducting interviews, follow-up and monitoring retaliation, first responder duties, and the facility's coordinated response plan.

The following staff were present during the audit opening: PREA Coordinator, Assistant Director, Compliance Specialist, Clinical Manager, Finance Manager, and the Executive Director. After a brief opening with agency staff, the auditor toured the facility. The tour consisted of examining all housing units, dorms, bathrooms, group areas, operations posts, recreation yards, utility areas, kitchen, and maintenance areas. A review of employee files, training records, PREA acknowledgments, PREA forms, and data logs was also completed. The auditor gave a closeout and shared some the immediate findings.

## DESCRIPTION OF FACILITY CHARACTERISTICS

The MonDay Community Based Correctional Facility is located in Dayton, Ohio and serves adult male and female felony offenders. The facility consist of two separate buildings, one for male residents and one for females. The male offender building has under gone a 48 bed expansion and continues to make improvements that will allow for complete separation from the female offenders. Currently the female offender still utilize the male building for some services. In order to access the secure perimeter of the facility one must report to the male resident building 1, be signed in by a receptionist, and sign a zero tolerance policy acknowledgment. Residents will enter at the intake entrance and receive a pat down or a strip search. The intake area also has a single use shower that can be used to allow transgender residents to shower privately. Female residents also processed through the intake area in building one. The facility plans on additional changes that will eliminate the need for females to be processed in the same building.

Building 1 contains the kitchen/dining area, commercial laundry, outdoor rec area, staff offices, group rooms, a library, medical, and male orientation housing unit. The clinician offices are located around the dayroom and all have windows with clear line of site views inside. The library off the dayroom has open hours but only one resident is allowed in for 30 minutes at a time. The commercial laundry is visible to the dayroom floor through a wall of windows and also has a camera inside. A registered nurse and a contracted doctor staff the medical area. Two psychiatrist visit the facility to provide services to the residents. All group rooms in this area have windows in the doors and cameras inside. The dining and kitchen areas have adequate camera coverage. The facility has an purchased additional camera to cover a bind spot area that leads to a staff restroom within the kitchen. Residents work in the kitchen under the direction of staff and are escorted into stock room areas. The stock room has a camera inside, the cooler has a window in the door, and the cage area has a window in the door and a camera. The dock and maintenance areas are off from the kitchen and have camera coverage. The recreation yard has a 16ft fence around it. Residents can only use this area with staff supervision.

The facility has three male housing units. The male housing unit in building 1 houses orientation residents. Residents are housed here for approximately 21-30 days. The dorm floor of building 1 has a night watch desk with a camera that can record audio and video. The camera is focused on the desk area and cannot see into the dorm or bathroom areas. This housing unit has a total of three dorms each set up the same. Each dorm area is divided into two pods by a half wall. The dorm areas have an open doorway with a locker area set up as the designated changing area. The facility has cameras in the dorms but no views into the changing area. The cameras in the dorm areas have no active views to the various monitors in the facility. Supervisory staff complete spot checks and female staff have no access. Residents that have been designated as vulnerable would be placed in a dorm and bed that is easily visible from the night watch desk. The three bathrooms in this housing unit are set up the same. The bathrooms have open doorways, non-reflective mirrors, two toilet stalls, and three single use shower stalls. Curtains that have clear tops and bottoms or have been cut to see feet cover the toilets and showers. Cameras that have views into the shower record to a separate server with no active views. Only the operations director, operations coordinator, and operations supervisors have limited access. No female staff have permission to view this area.

Building 2 contains administration, main post, resident entrance/exit, patio areas, elevator, indoor recreation area/visitation room, staff kitchen, group rooms, clinical hallway, library, outdoor recreation area, and two housing units. The clinical hallway and administration area are off limits to residents without a staff escort. Resident will not have individual counseling sessions in this area if there is only one staff working in the clinical hallway. Cameras cover the hallway areas. The facility elevator provides access to this area but staff and residents are not allowed to ride in the elevator together. The indoor recreation area has a basketball court with a walking track above. Residents are provided with rec time twice a day for 30 minutes. Visitation for both male and females are held in the indoor recreation area. Staff will escort female resident to building two where the court will be divided into male and female sections. There are camera views of the entire court and staff supervision. There is a kitchen located off the indoor recreation area that is only assessable to staff. The outdoor recreation area is surrounded by a 20ft curved fence and has camera surveillance. Resident Leaders supervise residents while in this area. All group rooms have windows in the doors and cameras in the rooms. Residents in building 2 eat in building 1. The residents are escorted down a hallway that has access to the dining area. At no time do the residents interact with the orientation residents housed in building 1.

Building 2 has two housing unit areas. Residents are separated into housing units based on Ohio Risk Assessment System (ORAS) score. One housing unit in building two have dorms with cameras that records both audio and video and security mirrors. The doors on the dorms have windows in the door and are locked during program hours. At night, the doors are propped open. This housing unit also has several two-person rooms. The bathroom in this housing unit has non-reflective mirrors, toilets, and showers. Shower curtains that have clear tops cover the toilets and showers. The camera in this bathroom area only views the sink area. Residents must sign in/out to use the restroom and only four residents can occupy the bathroom at any one time. The second housing unit also has security mirrors and cameras that record both audio and video. All housing units have the ability to "buzz" the main post to contact security staff.

The females are housed in Delta building. This facility is on the same campus but in a different building than the male facility. Staff must unlock the door for entrance into the facility. The facility is divided into two sections. One section contains space for offices and group rooms. During the daytime hours, all residents are moved to one wing for program activities. There is a recreation area that is enclosed by a fence and requires staff supervision while in use. The laundry room, group rooms, and offices all have windows in the doors and camera inside. The segregation cell is mainly used for medical purposes. There is a restroom inside the segregation cell and a window for clear line of site views. Administration at MonDay recently modified policy to ensure no male staff is working on the floor of this building into to ensure any female resident placed in the segregation cell would be able to use the restroom with privacy. The library located in this

building is locked until the facility can place a camera inside. Staff can view the cameras in this building from the Team Leaders office but cannot see the cameras located in the male building. The dining area is set up in day room area and food that is prepared in the male facility is brought to the female facility by staff.

The housing unit in the female facility has several sleeping pods. The pods are divided into rooms and sleep two-three residents per room. There are no doors to the rooms and the windows have been tinted. The pods each share a bathroom that contains a single use toilet and shower covered by a curtain. Unlike the male facility, there are no cameras in the female dorm areas.

The facility (both male and female buildings) have put in place several strategies to prevent, detect, and respond to sexual abuse and sexual harassment. The facility has placed security mirrors in strategic places to minimize blind spot areas; have an electronic key card system in the male facility; and provide residents with a way of contacting staff from inside the dorm if necessary. MonDay's electronic surveillance program includes 96 cameras placed throughout the facility (interior and exterior) and 38 cameras placed throughout the female facility (interior and exterior) that have the capability to record and playback up to 30 days. Some cameras are omnidirectional and have the capability to record audio as well as video. Camera footage is viewed by Resident Leader staff assigned to the main control post. Cameras that have views to sensitive areas cannot be seen at control post and require permission to access. These recordings are stored on a separate server with only administrative access. Supervisory staff have access to the facility camera system on their office desk top computer. Resident Leader staff are required to conduct three security checks per shift and every half-hour after lights-out. During a "where about" staff must document physically seeing each resident. Identified blind spot areas have increased circulation.

## SUMMARY OF AUDIT FINDINGS

MonDay Community Based Correctional Facility has had three (3) PREA allegations during the reporting period. Two allegation were resident-to-resident sexual harassment. Both allegations were substantiated. The third allegation was staff-to-resident sexual harassment which was determined unsubstantiated. None of the allegations were criminal in nature so no referral for criminal investigation to the legal authority was made.

The staff of MonDay indicated that they received formal PREA training during orientation training or as part of their annual training along with refresher training. Staff was able to specifically talk about their responsibilities as first responders, how they were to respond to any allegation reported to them or if they suspected incidents of sexual abuse/sexual harassment, how to communicate effectively with offenders who may be LGBTI, and impressed upon the auditor that their main duty was to keep everyone safe. Many of the staff were able to detail their experience working with the past transgender resident. They found their training to be helpful have not run into any barriers to treatment.

The offenders at MonDay expressed that they have no doubt that the staff would keep them safe and would respond appropriately should an incident of sexual harassment/sexual abuse take place. The offenders were able to clearly recite the education they received concerning their rights under the PREA standards, and knew the location of PREA related postings. All offenders affirmed being screened at intake for risk of vulnerability or abusiveness and again by their case manager at a later date.

All MOU's documented the partnership between the facility and the contracting agency concerning services to be provided should there be a need. The auditor was able to review the Miami Valley Hospital's website and confirmed the free services the agencies would provide to a victim of sexual abuse/assault.

Overall, the auditor was left with the impression that the leadership and staff of MonDay have made implementing the PREA standards a priority and that they have received the necessary training and authority to detect, protect, and respond to any incident of sexual abuse/sexual harassment. The auditor review the final PREA audit report from the last cycle and noted how the facility has reviewed the corrective action plans and have implemented positive changes that go beyond basic requirements. Opportunities to increase the ability to protect and detect sexual abuse and sexual harassment are proactive in nature. Facility leadership has developed policies and practices that shows a commitment to the safety of residents, and provides the necessary support to implement all aspects of the PREA standards.

Number of standards exceeded: 0

Number of standards met: 40

Number of standards not met: 0

Number of standards not applicable: 2

**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.**

Click here to enter text.
The facility has an agency wide written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment. The policy includes how the facility will implement its approach to preventing, detecting, and responding to sexual abuse and sexual harassment; definitions of prohibited behavior; sanctions for those found to have participated in sexual abuse or sexual harassment; and appropriate strategies to reduce and prevent sexual abuse and sexual harassment of residents.

The agency PREA Coordinator is the agency's Accreditation Manager, and reports directly to the agency's Executive Director. During staff interviews, the PREA coordinator indicated that she has enough time and authority to develop, implement, and oversee the facility's efforts to comply with the PREA standards. The Vice Executive Director agreed that the PREA Coordinator has great latitude toward implementing policy and procedure where PREA is concerned.

The agency also has a Compliance Specialist. The Compliance Specialist assist the PREA Coordinator and reports directly to the PREA Coordinator on issues pertaining to complying with the PREA standards. She indicates that she has ample time to comply with the PREA standards.

Review:
Policy and Procedure
Interview with PREA Coordinator
Interview with Executive Director
Interview with Compliance Specialist

**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)

**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.**

N/A: The PREA Coordinator advises that the facility is not a public agency and does not contract with other facilities.

**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)

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The facility has a staffing plan that provides for adequate levels of staffing, and where appropriate video monitoring to protect residents against sexual misconduct. The staffing plan takes into consideration the physical layout of the facility, types of residents housed at the facility, and the number of substantiated and unsubstantiated incidents. The facility management has considered all blind spot areas and developed an appropriate response to maintain the safety and security of the facility.

The staffing plan was developed with the agency PREA coordinator along with other facility leadership. The team reviews the previous plan and documents ways the facility can improve its methods of preventing and detecting any incidents of sexual abuse/sexual harassment. Staffing levels are continuously monitored and the facility has the ability to pull from either its male or female building if necessary to ensure appropriate coverage.

There have been no deviations to the staffing plan during this audit cycle. The facility has created a form to document the dates of any deviations, listed what the deviation was, and a justification for the deviation.

The auditor has reviewed the agency's written policy concerning what information is to be contained in the staffing plan and the number of staff members required to operate each shift. A review of floor plans, camera placement, and identified blind spot areas was conducted by the auditor prior to the audit and during the walk through. During interviews with facility staff, the auditor was informed how staff placement, security mirrors, required head counts and circulations, and video monitoring are used to ensure maximum safety and security. There is a policy requirement to have the staffing plan reviewed annually and updated if necessary.

CORRECTIVE ACTION:
There is a staff restroom in the kitchen that is tucked into a corner and is not visible to the camera and can hide activity from those working in the kitchen. Staff and/or residents could enter this restroom without being monitored.

FACILITY RESPONSE:
The facility has purchased a camera that is to be placed in the kitchen so that all who enter and exit this restroom ae viewable.

Review:
Policy and Procedure
Facility tour
Staffing plan
Deviation Report
Floor plans with camera placement/security mirrors
Interview with PREA Coordinator
Interview with PREA Compliance Specialist
Interview with Clinical Manager
Interview with Assistant Director
Interview with Operations Coordinator

### 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.**

The facility does not conduct cross-gender strip, pat-down, or cross-gender body cavity searches of residents except when performed by medical professionals. There is always a female staff member on duty, so no programming or other outside activities have been denied to female residents due to staffing. Pat-downs are completed near a camera view and supervisors will complete reviews in order to ensure proper professional searches are being conducted.

The facility allows residents to shower, perform bodily functions, and dress in areas not viewable to staff. The male facility is divided into two distinct facilities. The main housing unit contains three bathrooms. Each bathroom has an open doorway, non-reflective mirrors, individual shower stalls with shower curtains (clear tops and bottoms or the length has been cut to see feet), and individual toilet stalls with curtains for closures. The bathroom facilities are right off the night watch desk and have camera views into the open area of the bathroom. Cameras that have views of the bathroom are connected to a dedicated server that has limited access to management personnel. Female management staff members do not have access to the cameras in these areas. The facility does not allow female security staff members to work in the night watch desk where viewing into these areas is possible. The dorm areas have cameras therefore residents are required to dress in a designated dressing area located within each dorm. The camera views do not see into this area. The intake-housing unit has two bathrooms. Residents in this housing units must request permission to use the bathroom and no more than four residents can be in the bathroom at any given time. Each of the bathrooms have non-reflective mirrors, individual showers with curtains (clear tops and bottoms or the length has been cut short to see feet), and toilets with curtains as closures. The camera in this housing unit only covers that sink area. The female building has one housing unit that is divided into two wings. There is a single use restroom that is shared between the dorm rooms near that bathroom. There is a curtain that covers the toilet and shower areas. The female restrooms do not have cameras in the restroom or dorm areas. The agency has a dress policy that requires residents to be fully dressed in common areas.

The facility has housed a transgender female resident. The agency has implemented a policy addressing the proper housing, search, and showering of any transgender or intersex resident. The housing units have several dorms within each unit are set up where residents who are identified as highly vulnerable or highly abusive or transgender or intersex would be housed and in beds that are easily viewable to staff. A transgender or intersex resident would be offered showering options such as showering at different time in order to protect privacy and offer safety. The policy does not allow staff to physically examine a transgender or intersex resident for the sole purpose of determining genital status. The auditor discussed housing and bathroom issues with staff. The resident was a fully transitioned female and was housed in the female facility and treated like any other female resident. The resident was terminated unsuccessfully from the program due to violating program rules. The staff report there were no issues directly related to the residents transgender status. Staff interviewed report the experience allowed them to put into practice their training and that necessary adjustments have been made. No other issues have been reported.

Facility staff have received proper training for patting down a transgender or intersex resident. This training is completed during new staff orientation. A Shift Supervisor is required to periodically review pat downs, live or reviewing surveillance video, and provide training/guidance to staff if necessary. Reviews of this training is conducted annually. The current transgender residents was identified as such prior to placement and she was classified as a female with female staff conducting pat-down and strip searches.

CORRECTIVE ACTION:
The facility has a segregation cell in both the male and female building that has a window that allows for views of the toilet area. Residents who are placed in these cells and need to use the restroom can be seen by any staff or resident walking by and looking into the window.

FACILITY RESPONSE:
The facility has blackened out the window to the segregation cell in the male facility. The cell has another window that is not located in a place that has views to the open area. The female facility will now be staffed by only female security staff members. Covering the window would provide an unsafe environment and was not a viable option.

Review:
Policy and procedure
Staffing plan
Facility tour
Training records
Interview with PREA Coordinator
Interview with Compliance Specialist

Interview with Clinical Manager
Interview with Operations Coordinator
Interview with Clinician
Interview with random Resident Supervisor staff
Interview with residents

**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.**

The facility has a list of Supreme Court of Ohio Court Interpreters to provide disabled resident equal opportunity to participate in all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The facility identifies residents who may be limited English proficient and works with interpreters so that residents can benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Per policy, the facility will only rely on resident interpreters if a delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-responder duties, or the investigation of the resident's allegations.

Staff are trained on how to ensure that PREA is communicated with residents having a cognitive or physical disability and who to call to help residents who may have a language barrier. The facility will use a qualified employee to aid any resident in understanding agency rules, PREA, and other regulations. If a qualified staff member is unavailable, outside assistance by a qualified person will be used at no cost to the resident. At this time, the facility does not have a resident who is in need of these services.

Interviews with staff and a review of agency policy confirmed the process of how the facility would assist any resident with a disability or is limited English proficient.

Review:
Policy and Procedure
Training Curriculum
Interview with PREA Coordinator
Interview with Clinical Manager
Interview with Intake staff

**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)

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

The agency has a policy that prohibits hiring or promoting anyone who may have contact with the residents and prohibits the services of any contractor who may have contact with residents who: has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution; has been convicted or engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied treats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or has been civilly or administratively adjudicated to have engaged in the activity described in the above section.

The agency conducts a background check for all prospective employees, including temporary employees, independent contractors, volunteers, and student interns or required the contractor, vendor, volunteer to provide a background check. Record checks will be completed every five years. Every five years the Human Resource Department will run background checks on the entire facility regardless when a person was hired in order to guarantee all staff received the required updated check. All employees, independent contractors, volunteers, and interns are required by policy to immediately report to their supervisor any arrests, citations, and complaints to professional licensing boards. Employees document this continued affirmation during annually.

All successful applicants are notified of the PREA background check requirement and that any omission regarding sexual misconduct is grounds for termination. Employees are required to document their adherence to this policy.

The Human Resource Department will review the personnel file, specifically any disciplinary action, of any employee who is up for a promotion.

The Human Resource Department conducts referral checks for all new hires and specifically documents whether or not a potential employee has been found to have substantially sexually abused an offender or resigned during a pending investigation of an allegation of sexual abuse.

The auditor conducted a review of ten randomly chosen employee's files and confirmed the background checks (initial and five-year update), documentation of the continual affirmation to disclose any sexual misconduct, referral checks, and the promotion process. The auditor conducted an interview with the Director of Human Resources who took the auditor systematically through the hiring and promotion process.

Review:
Policy and procedure
Employee files
On boarding documentation
Interview with Human Resources staff

### 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)

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The facility has not acquired a new building or made any substantial expansion or modification to the existing facility.

The facility has plans for increasing the number of cameras in the female building. These cameras will be placed in female f=dorm areas and will have the ability to record audio as well as video. No other electronic surveillance system or other monitoring technology has been changed. The facility will address any needs to these areas as the budget allows.

Review:
Policy and procedure

Interview with Executive Director
Interview with PREA Coordinator

### 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)

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The facility has eight trained investigators to conduct administrative sexual abuse investigations. The Montgomery County Sheriff's Office is responsible for conducting criminal investigations. The agency has made several attempt to enter into an MOU with the sheriff's department that has the legal authority to conduct criminal investigations at the facility. At this time, the agency has not had a response from that legal authority.

The facility will use Miami Valley Hospital to provide a Sexual Assault Nurse Examiner for any resident who is a victim of sexual abuse. The auditor confirmed that any resident taken to this hospital would be treated by a certified SANE nurse. The services provided by the hospital would be at no cost to the resident.

The facility has a MOU with Montgomery County Prosecutor's Office: Victim Witness Division to provide a victim advocate to any victim of sexual abuse, and a trained staff member who can provide victim support services.

The facility also has a clinician and other trained emotional support staff that can provide emotional supportive services or make a recommendation for outside services if necessary. These services will be provided to the resident at no cost. The services were confirmed with the agency.

CORRECTIVE ACTION:
The standard does not allow for the use of supportive services that are directly linked to the criminal justice system. Since the Victim Witness Division is a part of the prosecutor's office, it cannot be used to provide these services.

FACILITY RESPONSE:
The facility has a licensed clinician as well as trained emotional support staff to provide emotional support services to victims of sexual abuse or assault when requested by the victim. The facility will use Montgomery County Prosecutor's Office: Victim Witness Division address as an available option for standard 115.253.

Review:
Policy and Procedure
Emails to local legal authority
MOU with Montgomery County Prosecutor's Office
Interview with Administrative Investigators
Interview with PREA Coordinator
Miami Valley Hospital's website
Interview with Clinician

### 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 agency has a policy that requires an administrative investigation of all allegations of sexual abuse and sexual harassment, and that any allegation that is criminal in nature is referred to the Montgomery County Sheriff's Office. The facility has not had an allegation of sexual harassment or sexual abuse that needed referring for a criminal investigation during this auditing period.

The facility conducted three administrative investigations during this audit cycle:

Investigation #1: A resident made a sexual harassment complaint against another resident. This allegation was verbally reported to staff. The facility initiated an administrative investigation and determined that the allegation substantiated. There was no criminal activity involved so the incident was not referred to the Montgomery County Sheriff's Office.

Investigation #2: A resident made a written voyeurism allegation against a staff member. The facility conducted an administrative allegation and determined the allegation unsubstantiated. There was no criminal activity involved so the incident was not referred to the Montgomery County Sheriff's Office.

Investigation #3: A resident made a sexual harassment complaint against another resident. This allegation was verbally reported to staff. The facility initiated an administrative investigation and determined the allegation substantiated. There was no criminal activity involved so the incident was not referred to the Montgomery County Sherriff's Office.

MonDay's website post the investigative policy of the agency and the responsibilities of both the agency and the investigating entity. The auditor reviewed the agency's website and confirmed that the appropriate policy was posted.

Review:
Policy and procedure
MonDay website
Interview with PREA Coordinator
Interview with Compliance Specialist
Interview with Administrative Investigators
Review of investigations

### 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.**

The agency has trained all staff on the PREA required topics. The agency uses Relias, an online training system, to ensure all staff know the proper way to prevent, detect, report, and respond to any allegations of sexual abuse or sexual harassment. Staff also receive refresher training every other year that includes a review of MonDay polices and procedures, staff duties and responsibilities, and the first responder coordinated response plan.

During staff interviews, all staff were able to discuss the various PREA related training they received at orientation or during one of the annual training sessions. Staff was well versed on the PREA policies and protocols.

The agency cross-trains its staff because staff can be transferred to work in any facility. All staff received gender specific training.

All staff sign an acknowledgment of the training they received if it is not electronically documented in the Relias system.

Supervisors are to ensure that the required training is complete each year.

Review:
Policy and procedure
Training curriculum
Training records
Interview with PREA Coordinator
Interview with Human Resource Director
Interview with Clinical Manager
Interview with Compliance Specialist
Interview with random staff

### 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.**

The facility's Compliance Specialist completes PREA training for all volunteers that have contact with residents. This training includes their responsibilities under the facility's sexual abuse and sexual harassment prevention, detection, and reporting polices. There were no volunteers or contractors on duty during the audit; however, the facility maintains documentation of the training curriculum and sign-in sheets verifying the training received.

The auditor interviewed the trainer and ensured that the proper training was given to volunteers and contractors based upon their level on involvement with the residents.

Review:
Policy and procedure
Contract/vendor training
Training sign-in sheet
Interview with Compliance Specialist

### 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.**

All residents receive information at the time of intake about the facility's zero tolerance policy, how to report incidents or suspicions of sexual abuse or sexual harassment, their rights to be free from sexual abuse and sexual harassment, and to be free from retaliation for reporting such incidents. This information is read and reviewed with all residents to ensure each resident understands their rights under the PREA guidelines. If a resident does not understand English or has other disabilities that prevent normal communication, the facility contracts services with other agencies so that each resident can benefit from the facilities efforts to prevent, detect, report, and respond to sexual abuse and sexual harassment (See standard 115.216). Residents sign acknowledgment of receiving this information.

All residents watch a PREA education video during orientation and receive handouts that include ways to report and reporting phone numbers. This information is also on posters located throughout the facility. During this orientation group, the facilitator ensures that residents understand the services available to them at no cost and the limits to confidentiality.

During resident interviews, all offenders reported receiving the PREA education and information at intake and during orientation group. Residents also indicated that their case managers reviewed ways to keep themselves safe, how to report including anonymously, and the toll free numbers posted near the phones. Postings with PREA related information was located in conspicuous areas throughout the facility.

Review:
Policy and procedure
Resident training curriculum
PREA postings
Facility tour
Interview with residents
Interview with Clinical Manager
Interview with Case Manager
Interview with Resident Leaders

### 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.**

The facility has a standardized process for administratively investigating any allegations. The facility has eight administratively trained investigators including the PREA Coordinator and the Compliance Specialist. The training included techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, evidence collection in a confinement setting, and required evidence to substantiate a case for administrative action or criminal referral. The training was provided by the Moss Group or online with NCIC.

Review:
Policy and procedure
Administrative Investigator training curriculum
Administrative Investigator training certificate
Interview with Administrative Investigators

**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.**

The facility provides all full and part time medical and mental health practitioners that work within the facility how to detect and assess the signs of sexual abuse and sexual harassment; how to preserve any physical evidence of sexual abuse; and how to effectively respond to allegations or suspicions of sexual abuse and sexual harassment.

The medical staff at the facility would not complete a forensic examination. Should one be necessary, the resident would be taken to Miami Valley Hospital which has a sexual assault nurse examiner program.

Interviews of the clinician indicate she knows how and whom to report allegations of sexual abuse and sexual harassment.

Review:
Policy and procedure
Interview with Clinical Manager
Interview with PREA Coordinator

**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.**

All residents are screened for risk of vulnerability or abusiveness at intake. The screening tool used included all required criteria in order to accurately assess the resident's risk. The clinician will complete the initial screening and the rescreen with all residents. The policy does not allow for a resident to be disciplined for refusing to answer or for not disclosing complete information in response to questions on the resident's mental health, sexuality, or previous victimization.

The auditor reviewed several initial screening and rescreening to ensure that they were completed within the specified time frame and that all required criteria was used in the screening. All residents get a 30-day rescreen and a rescreen will also be completed if the facility receives any additional new information or if a PREA allegation occurred regardless of the time frame.

Should a classification of potential victim or potential abuser be made during the screening, appropriate staff would be notified and accommodations if necessary would be made. Should a resident need additional services, the clinician would complete an assessment and make a referral to the psychiatrist.

Quality assurance checks are completed to ensure screenings are completed appropriately.

Review:
Policy and procedure
Initial PREA assessment screen
PREA assessment rescreen
Interview with Clinical Manager
Interview with residents
Interview with Treatment Coordinator
Interview with Resident Supervisors

### 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.**

All residents receive a classification based upon their PREA screening information. Classifications include none, potential victim and potential abuser. A resident's classification will be documented but no staff member will be able to see the screening form or answers. Any resident who is classified as potentially vulnerable or potentially abusive will be housed in a designated dorm with a bed that is easily viewable by staff.

All residents with a classification have it addressed with treatment goals. These residents work with their case worker to work on the issues underlining their classification and residents can also be referred to counseling if necessary.

The facility has a plan for housing a transgender or intersex resident safely which include opportunities to shower separately and make housing and program assignments with a transgender or intersex resident's own views taken into consideration. The agency has developed a team that will address placement issues for any transgender/intersex resident housed with agency. These determinations are made on a case by case basis.

The auditor and facility management discussed the facility's plan to house residents that are highly vulnerable, highly abusive, or transgender/intersex. The facility was able to describe specific bed placement, group separation, ability to shower separately, and the protocol on safely housing transgender/intersex residents as ways to ensure the safety of each resident.

Interviews with line staff revealed that they have received proper training on how to manage a transgender/intersex resident safely.

Review:
Policy and procedure
Facility tour
Initial PREA assessment screening
PREA re-screen assessment
Individual case plan
Staffing plan
Interview with Case Managers
Interview with Resident Leaders
Interview with PREA Coordinator
Interview with random residents

### 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.**

Residents at MonDay have multiple ways of reporting sexual abuse. Posters throughout the facility indicate how residents can report as well as how to report to an outside agency. Interviews with the residents indicate that they are aware of all means of reporting and that they could report anonymously. They received the information at intake, during orientation training, and in case manager meetings.

The facility has facility phones with the reporting numbers along with a special code (9732#) available to residents. This allows residents to make toll free reports and/or anonymous reports to an outside agency.

All residents received information at intake and in their handbooks regarding PREA reporting. Staff received information on how to privately report during staff training.

The auditor interview random residents who were able to describe the various ways that they could report and allegation including anonymously and directly to any staff member. The residents felt comfortable enough to report any problem directly to staff feeling confident that staff would address the situation appropriately.

Review:
Policy and procedure
PREA postings
PREA brochure
Facility tour
Interview with PREA Coordinator
Interview with Clinical Manager
Interview with residents

### 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.**

The facility does have a formal grievance process; however, residents are not required to use the system in order to make an allegation of sexual abuse or sexual harassment. Should a resident use the grievance system to make an allegation, the facility does not require the use of an informal process such as submitting a complaint form or require an attempt to resolve the issues with staff. There is no time limit imposed on when a resident may submit a grievance alleging sexual abuse or sexual harassment.

All grievances related to sexual abuse or sexual harassment will have a final decision based on the merits of the allegation within 90 days of the initial filing of the grievance. Should the facility need more time to make a determination, the facility may extend the time frame for up

to 70 days. The resident will be given written notification if an extension is necessary.

Third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, are permitted to assist residents in filing request for administrative remedies related to sexual abuse or sexual harassment allegations. If a third party files a request on behalf of a resident, the alleged victim is required to agree to the have the request filed on his or her behalf.

Should a resident need file an emergency grievance alleging substantial risk of imminent sexual abuse, the facility will initiate immediate corrective action. The resident will receive a response in no more than 24 hours and have a final decision within 5 days.

A resident will be disciplined for filing a grievance relating to sexual abuse only when is can be proved the grievance was written in bad faith.

The facility has not received an allegation through its grievance system. The auditor spoke with several random residents and reviewed the grievance process with them. All report receiving instruction on how to file a grievance during intake and understood how to use the system properly.

Review:
Policy and Procedure
Interview with PREA Coordinator
Interview with Operations Manager
Interview with random resdients

### 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.**

The facility has a MOU with the Victim Witness Division of the Montgomery County Prosecutor's Office to provide emotional support to any resident who is a victim of sexual abuse. The facility provides the phone number and address of this agency to residents as wells as train them during orientation of the limitations to confidentiality and mandatory reporting.

Residents who were interviewed verified that they received this information and that the information is available on posters located throughout the facility.

The auditor took note of the information on posters located throughout the facility and ensured that the posting contained all the accurate information. A review of the MOU was also completed.

The auditor reviewed the services available to any resident who may need emotional support after an incident of sexual assault/abuse. These services would be provided to any resident who made contact with the agency. The facility would not assist in allowing this agency to provide advocate services after an incident of sexual assault or sexual abuse due to the agency operating out of the prosecutor's office (See Standard 115.221 D). The agency has trained staff that can offer victim support services at the request of the victim.

Review:
Policy and procedure
MOU Montgomery County Prosecutor's Office Victim Witness Division
Emotional Support Training Certificate
Interview with PREA Coordinator

Interview with Clinical Manager

### 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.**

The agency has posted on its website ways that anyone can report sexual abuse or sexual harassment on behalf of a resident. Residents are also educated that they can report to family members who can then make a third party report. This information is also on posters located in areas the general public would see.

The facility has not had a third party report.

Review:
Policy and procedure
MonDay website
PREA postings
Facility tour
Interview with Administrative Investigators
Interviews with random residents

### 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.**

MonDay CBCF policy requires all employees to immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment including third party and anonymous reports. Apart from the employee's supervisor, no one shall reveal 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. All allegations of sexual abuse or sexual harassment are reported to the facility's investigators.

The auditor interviewed all required specialized staff and several random staff members. All staff members indicated that they were given and understand the agency's policy on reporting PREA incidents and were trained on the appropriate way to document a report and to whom they should report an allegation. Staff indicated they understood that they are required to report their own suspicions, or information regarding sexual abuse, sexual harassment, or retaliation.

All staff members with a duty to report based on local law and medical and mental health practitioners are required to inform residents of

their status and the limitation of confidentiality at the initiation of services. Interviews with staff members who have a duty to report indicated that they understood their duty to inform residents before providing services.

The facility does not admit residents under the age of 18. The State of Ohio does not require institutions or facilities licensed by the state or facilities in which a person resides as a result of voluntary, civil, or criminal commitment to report to adult protective services (Chapter 5101:2-20 and 5101:2-20-01).

Review:
Policy and procedure
Ohio revised code
Investigation reports
Interview with random staff
Interview with Administrative Investigators
Interview with Treatment Coordinator
Interview with Clinical Manager

### 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.**

MonDay has several ways in which to protect residents from sexual abuse, sexual harassment, and retaliation. The facility can move residents to different housing units or rooms as well as move staff to a different building or placing them administrative leave during the course of an investigation or after to prevent retaliation. During the interview process, it was very clear that the safety and security of all residents is their primary concern.

An interview with the PREA Coordinator and Agency Investigators describe the process on how they determine if an alleged victim or abuser should be moved in order to protect the victim from imminent abuse. The practice is to place a staff member on administrative leave or place in another facility (if possible) if they are accused of sexual harassment or sexual assault during the investigation. The staff member is to have no contact with the facility or other staff member until a determination has been made. If another resident is the alleged abuser, the abuser and victim will be separated either by housing unit or facility until a determination has been made.

The facility has had three sexual harassment investigations during this audit cycle. During the investigation into two resident on resident allegations, the alleged victim was moved to a different pod in an effort to keep them safe.

Review:
Policy and procedure
Investigation reports
Interview with Administrative Investigators
Interview with PREA Coordinator
Interview with Clinical Manager
Interview with Operations Coordinator

### 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.**

Upon receiving an allegation that a resident was sexually abused while confined at another corrections facility, the Executive Director shall notify in writing the head of the facility or appropriate central office of the agency where the alleged abuse occurred and inform the PREA Coordinator. The policy requires notification within 72 hours.

Interviews with the Agency's PREA Coordinator and the facility's Compliance Specialist confirmed this practice.

The facility provided documentation of reporting an allegation to another facility within the specified 72 hour time period. The facility received a report from another agency; however was unable to make a determination based on the lack of availability of video surveillance or witnesses, nor were they able to locate the alleged abuser.

Review:
Policy and procedure
Interview with Executive Director
Interview with PREA Coordinator
Review of reporting documentation

### 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.**

MonDay has a policy outlining first responder duties for any allegation of sexual abuse. The policy contains instructions for how to separate the abuser and victim, protect and preserve evidence until appropriate authorities can collect it, not to allow the abuse to destroy evidence, request that the victim does not destroy any evidence, and enacting the PREA coordinated response plan, can collect it. All staff are trained on first responder duties (security and non-security staff) including reviewing potential scenarios.

Interviews of security and program staff indicate that staff know the appropriate steps to take to preserve and protect evidence and support the victim. All staff seemed comfortable with the first responder duties and confident that they would respond appropriately based upon their training.

Each security post has a posting of the first responder duties and coordinated response plan.

The facility has not had an allegation of sexual abuse during this audit cycle.

Review:
Policy and procedure
Coordinated response plan/first responder duties posting
Training records
Interviews with random staff

**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.**

MonDay has an appropriate written coordinated response plan to respond to any incident of sexual abuse. The plan includes the steps to take for first responders, medical and mental health practitioners, investigators, and facility leadership. All staff is trained on the plan and this was confirmed through interviews with security and program staff.

While on the tour, the auditor noted that the written coordinated plan is located at each security post in the facility. The information is within a book which is highly visible and clearly marked.

During staff interviews, staff knew and could articulate the coordinated response plan. All staff knew the entire plan and did not differentiate between security and non-security tasks. Staff was able to disclose the location of the plan and discussed how they practice using the plan in various scenarios during training.

Review:
Policy and procedure
Coordinated response plan/first responder duties posting
Interview with random staff

**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)

**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.**

N/A: The PREA Coordinator indicates that the facility is not under any collective bargaining agreements – a non-union agency.

**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.**

The agency has a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation. The facility has assigned the PREA Coordinator or supervisory designee as the staff responsible for monitoring against retaliation for at least 90 days. In the case of resident victims, a status check is completed by the facility's emotional support person or if necessary the agency's clinical manager.

The facility has the ability to move victim, offender, or employees to other parts of the facility in order to protect against retaliation. Staff members can be placed on administrative leave if necessary.

Interviews with the agency's PREA Coordinator, the Program Manager, and the Program Administrator confirmed the monitoring process. The auditor reviewed the form that is to be completed for status checks and the team would review the status reviews to determine if an extension in monitoring is necessary.

The facility has not had an allegation of sexual abuse or sexual harassment during this audit cycle where a retaliation watch was necessary.

Staff verified during interviews that their PREA training includes how to detect and protect others from retaliation, and that they have a right to be free from retaliation when reporting or cooperating in an investigation. Residents also verified that they have received information on their right to be free from retaliation.

Review:
Policy and procedure
Training records
Interview with Clinical Manager
Interview with Operations Coordinator
Interview with PREA Coordinator
Interview with Human Resource Director
Interview with random staff
Interview with random residents

### 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.**

All allegations of sexual abuse or sexual harassment including third party and anonymous reports are administratively investigated by a trained investigator and any report that appears criminal in nature are referred to the Montgomery County Sheriff's Office who has the legal authority to conduct a criminal investigation.

The agency investigators were interviewed and walked through their process of investigating any PREA related complaint and how this information is used determine whether an allegation is substantiated, unsubstantiated, or unfounded. The investigators collect all relevant

information (interviews with staff, victim, witness, and the abuser; review any surveillance information, and make note of any facility issue that could have aided in the allegation) and pass this information along with a recommendation to the PREA Coordinator. The PREA Coordinator determines the outcome of the investigation.

The investigators written report includes whether staff actions or failures to act contribute to the abuse and a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. The investigator would work closely with the sheriff's office should the facility have an allegation that needed criminal referral. The outcome of the investigation would be reported to the resident by the PREA Coordinator.

The PREA Coordinator maintain all records from all allegations for as long as the abuser is incarcerated or employed by the agency, plus five years.

The auditor discussed with the administrative investigators their assessment for how a case would be determined to be substantiated, unsubstantiated, or unfounded, and their process for referring to legal authority for a criminal investigation.

The facility conducted three administrative investigations during this audit cycle:

Investigation #1: A resident made a sexual harassment complaint against another resident. This allegation was verbally reported to staff. The facility initiated an administrative investigation and determined that the allegation substantiated. There was no criminal activity involved so the incident was not referred to the Montgomery County Sheriff's Office.

Investigation #2: A resident made a written voyeurism allegation against a staff member. The facility conducted an administrative allegation and determined the allegation unsubstantiated. There was no criminal activity involved so the incident was not referred to the Montgomery County Sheriff's Office.

Investigation #3: A resident made a sexual harassment complaint against another resident. This allegation was verbally reported to staff. The facility initiated an administrative investigation and determined the allegation substantiated. There was no criminal activity involved so the incident was not referred to the Montgomery County Sherriff's Office.

Review:
Policy and Procedure
Interview with Administrative Investigators
Review investigation reports

### 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.**

By agency policy and confirmed by investigators and PREA Coordinator interviews, the agency imposes a standard of preponderance of evidence or 51% to substantiate an allegation of sexual abuse or sexual harassment.

The PREA Coordinator makes the final determination of investigation outcome.

Review:
Policy and Procedure
Interview with Administrative Investigators
Interview with PREA Coordinator

**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.**

The PREA Coordinator is responsible for informing a resident who alleges sexual abuse the outcome of the investigation. The facility request information from the legal authority if the investigation is criminal in nature to inform the alleged victim of the outcome of an investigation.

The notice includes whether the abuser, if a staff member, is no longer posted in the resident's unit; no longer employed at the facility; has been indicted on a charge related to the sexual abuse within the facility; or has been convicted on a charge related to sexual abuse within the facility. The notice includes whether the abuser, if another resident, has been indicted on a charge related to sexual abuse within the facility or has been convicted on a charge related to sexual abuse within the facility.

All residents who alleged some type of PREA allegation during this audit cycle received a notice of investigation outcome from the PREA Coordinator and signed that they had received such notice.

Review:
Policy and procedure
Review outcome notice
Interview with PREA Coordinator

**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.**

MonDay outlines its progressive disciplinary plan in its policy and procedure. A review of the policy states that any staff member found to have engaged in sexual abuse will be terminated. Termination or resignations by staff will not void an investigation and any criminal activity will be reported to the legal authority and to any relevant licensing agency. Policy also indicates that the agency will notify law enforcement or any relevant licensing boards of any terminations or resignations based upon violations of the agency's resident sexual abuse and sexual harassment prevention policy when such behavior is criminal in nature.

All staff interviewed understood that anyone engaging in sexual harassment will be disciplined according to agency policy and that they

would be terminated for participating in sexual abuse. Staff indicated that they are required to report any suspicion to their immediate supervisor and that they would not have any issue reporting a coworker for violation of the zero tolerance policy.

The auditor reviewed agency policy, the employee handbook, and interviewed the Executive Director, PREA Coordinator, and Human Resource Director to confirm the disciplinary process for employees found to have substantially engaged in sexual harassment or sexual abuse against residents. All agency leadership stated that any employee found to have engaged in sexual abuse will be immediately terminated from the facility and law enforcement would be notified.

Review:
Policy and procedure
Employee handboo
Interview with Human Resource Director
Interview with Administrative Investigators
Interview with random staff members
Interview with PREA Coordinator

### 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.**

All contractors and volunteers are made aware of the agency's zero tolerance policy toward sexual abuse and sexual harassment. Each must participate in PREA training where they will be taught how to prevent, detect, respond, and report sexual harassment and sexual abuse. They will also learn the consequences of participating in any type of sexual misconduct. Contractors and volunteers sign an agreement that they could be removed from the facility for any acts of sexual abuse or sexual harassment.

The auditor has reviewed the contractor/volunteer training and documentation of compliance with training.

The facility has not removed any contractor or volunteer for a PREA issue.

The PREA Coordinator discussed how contractors/volunteers are trained and the process for ensuring everyone is aware of the Zero Tolerance policy.

Review:
Policy and procedure
Contractor/volunteer sign-in sheet
Contractor/volunteer training curriculum
Interview with PREA Coordinator

### 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.**

A review of the resident handbook shows how it outlines resident conduct and prohibits all sexual activity between residents and disciplines residents for such activity. Residents are given a handbook at intake and the contents are reviewed with the resident. Consensual sexual contact between residents is not considered a PREA violation.

During resident interviews, all residents affirmed that they received a handbook at intake and the rules and discipline policies regarding sexual abuse and sexual harassment were reviewed with them. All residents interviewed understood fully the seriousness of the agency's Zero Tolerance Policy and the consequences of participating in sexual misconduct.

Residents reporting allegations of sexual abuse and sexual harassment will not be disciplined if the report is made in good faith based upon reasonable belief that the alleged contact occurred regardless if an investigation does not establish evidence sufficient to substantiate an allegation.

The two substantiated allegations involving resident on resident sexual harassment led to in-house disciplinary actions.

Review:
Policy and procedure
Resident handbook
Interviews with residents
Interview with PREA Coordinator
Interview with Operations Coordinator
Investigation reports

### 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.**

Policy indicates the types of service offered free of charge to an alleged victim of sexual assault. It is documented which types of services where rendered and or declined by the alleged victim on the first responder form. Residents are offered timely information about and timely access to sexually transmitted infection prophylaxis and emergency contraception.

If services are necessary, the Clinical Manager will provide appropriate referrals to the psychiatrist or to community resources and notify the case manager assigned to the resident. The scope of services provided will be determined by the licensed practitioner.

Staff have been notified of the facility's plan on providing services after a sexual abuse/assault incident. The plan outlines how staff is to offer unimpeded access to both emergency and ongoing medical and mental health care. Ongoing medical or mental health care will be at the discretion of the medical provider and is again at no cost to the resident.

First Responder forms indicate if services were offered and accepted or declined.

Resident are informed of their right to free services during PREA education at orientation.

The facility has not had a sexual abuse/sexual assault allegation.

Review:
Policy and procedure
Coordinated Plan
Investigation reports
Interview with PREA Coordinator
Interview with Clinical Manager

### 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.**

This facility offers community medical and counseling services for residents who have been sexually abused in jail, lockup, or juvenile facility. This treatment includes testing for sexually transmitted disease. Treatment is offered to all known residents on resident abusers within in 60 days of learning such history. All treatment offered is free of charge.

Staff have been notified of the facility's coordinated response plan. The plan outlines how staff is to offer unimpeded access to both emergency and ongoing medical and mental health care. Ongoing medical or mental health care will be at the discretion of the medical provider and is again at no cost to the resident.

The facility has not had a report of any known resident on resident abuser.

A review of the first responder form shows how staff indicates whether services were offered and accepted or declined. The PREA initial screening form indicates whether a resident has abused others while in a correctional setting. If a resident indicates that he has in fact abused another resident while in a corrections setting, the agency's Clinical Manager will make a determination if additional treatment or referrals for community treatment is necessary.

The facility had not a report of a resident being sexually abused while in a jail, lockup, or juvenile facility.

The PREA Coordinator has confirmed the process and practice of how staff will provide unimpeded access to necessary emergency and/or ongoing medical and mental health services.

Review:
Policy and procedure
Coordinated response plan
PREA initial assessments
Interview with Clinical Manager
Interview with PREA Coordinator

### 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.**

MonDay has an agency policy on a review of all substantiated or unsubstantiated allegations of sexual abuse within 30 days of the conclusion of the investigation. The review team includes the assigned regional PREA Coordinator, Compliance Specialist, Clinical Manager, Operations Coordinator, input from a designated Resident Leaders and/or Caseworker, Administrative Investigator, and any other employee deemed appropriate.

The team, per policy, considers whether a change in policy or practice will better prevent, detect, or respond to sexual abuse; if the incident or allegation was motivated by race, ethnicity, gender identity, gang affiliation, or any other group dynamic; if any physical barriers in the area enabled the abuse; adequacy of staffing levels; and whether monitoring technology should be deployed or augmented to supplement supervision by staff.

MonDay has no allegations of sexual abuse or sexual assault that would require a SART review during this audit cycle, but the auditor has reviewed the incident review form and it covers all required areas. Interview with PREA Coordinator indicates that all executive approved recommendations will be implemented the facility will document implementation or the reason for not implementing.

Review:
Policy and procedure
Sexual Abuse/Harassment Review Team report
Interview with PREA Coordinator

### 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.**

MonDay has an agency policy for data collection and statistical reporting of all necessary information in the most recent version of the Survey of Sexual Violence. The auditor reviewed the most recent information collected by the agency and has confirmed that the agency collects the appropriate data on all allegations of sexual abuse and aggregates this information annually.

The facility's PREA Coordinator collects the data and completes the Survey of Sexual Victimizations.

The agency has not received a request to supply the Department of Justice with this information.

Review:
Policy and procedure
SSV-4
Interview with PREA Coordinator

### 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 uses information collected in 115.287 to make improvements in how the agency prevents, detects, and responds to incidents of sexual abuse and sexual harassment. The report compares the current year's data with those of previous years, and includes the updates made from previous year's reports. The information contained in the report is based on a calendar year and the report with this information can be found on the agency's website.

The information in the report has been reviewed and approved by the Executive Director.

The information in the report does not contain any identifying information that would need to be redacted in order to protect the safety of an individual or the facility.

Auditor verified that the reported was posted on the agency's website (www.mondaycbcf.com) and that the report contained all required information.

Review:
Policy and procedure
PREA annual report
MonDay CBCF website
Interview with Executive Director
Interview with PREA Coordinator

### 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.**

All data collected in sexual abuse cases are securely maintained by the PREA Coordinator for a minimum of 10 years. The PREA Coordinator confirmed the retention schedule.

The aggregated information from the facility was posted on its website.

There is no information in the report that would identify any individual or jeopardize the safety or security of the facility.

Review:
Policy and procedure
PREA annual report
MonDay CBCF website
Interview with PREA Coordinator

**AUDITOR CERTIFICATION**

I certify that:

☒ The contents of this report are accurate to the best of my knowledge.

☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Kayleen Murray — September 7, 2017

Auditor Signature — Date