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

☐ **Interim** ☒ **Final**

Date of Report April 14, 2020

Auditor Information

Name:	**Email:**
Company Name: PREA Auditors of America, LLC	
Mailing Address: 14506 Lakeside View Way	**City, State, Zip:** Cypress, TX 77429
Telephone: 713-818-9098	**Date of Facility Visit:** December 18-19, 2019

Agency Information

Travis County Community Justice Services		Texas Department of Criminal Justice	
Physical Address: 411 W. 13th St		**City, State, Zip:** Austin, TX 78701	
Mailing Address: 411 W. 13th St		**City, State, Zip:** Austin, TX 78701	
The Agency Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☒ State	☐ Federal
Agency Website with PREA Information: N/A			

Agency Chief Executive Officer

Name:	
Email:	**Telephone:**

Agency-Wide PREA Coordinator

Name:	
Email:	**Telephone:**
PREA Coordinator Reports to:	**Number of Compliance Managers who report to the PREA Coordinator:** 0

Facility Information

Name of Facility: Travis County SMART Program			
Physical Address: 3404 FM 973		**City, State, Zip:** Del Valle, TX 78617	
Mailing Address (if different from above): Click or tap here to enter text.		**City, State, Zip:** Click or tap here to enter text.	
The Facility Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☒ State	☐ Federal
Facility Website with PREA Information: N/A			
Has the facility been accredited within the past 3 years? ☐ Yes ☒ No			
If the facility has been accredited within the past 3 years, select the accrediting organization(s) – select all that apply (N/A if the facility has not been accredited within the past 3 years): ☐ ACA ☐ NCCHC ☐ CALEA ☐ Other (please name or describe: Click or tap here to enter text. ☒ N/A			
If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe: Click or tap here to enter text.			
Facility Director			
Name:			
Email:		**Telephone:**	
Facility PREA Compliance Manager			
Name:			
Email:		Telephone:	
Facility Health Service Administrator			
Name:			
Email:		**Telephone:**	

Facility Characteristics	
Designated Facility Capacity:	116
Current Population of Facility:	110
Average daily population for the past 12 months:	114
Has the facility been over capacity at any point in the past 12 months?	☒ Yes ☐ No
Which population(s) does the facility hold?	☐ Females ☐ Males ☒ Both Females and Males
Age range of population:	18-99
Average length of stay or time under supervision	13-20 weeks
Facility security levels/resident custody levels	Community Confinement

Number of residents admitted to facility during the past 12 months	454
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:	417
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *30 days or more:*	332
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	☐ Yes ☒ No

Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):	☐ Federal Bureau of Prisons ☐ U.S. Marshals Service ☐ U.S. Immigration and Customs Enforcement ☐ Bureau of Indian Affairs ☐ U.S. Military branch ☐ State or Territorial correctional agency ☐ County correctional or detention agency ☐ Judicial district correctional or detention facility ☐ City or municipal correctional or detention facility (e.g. police lockup or city jail) ☐ Private corrections or detention provider ☐ Other - please name or describe: Click or tap here to enter text. ☒ N/A

Number of staff currently employed by the facility who may have contact with residents:	50
Number of staff hired by the facility during the past 12 months who may have contact with residents:	15

Number of contracts in the past 12 months for services with contractors who may have contact with residents:	2
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	31
Number of volunteers who have contact with residents, currently authorized to enter the facility:	8
Physical Plant	
Number of buildings: **Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.**	5
Number of resident housing units: **Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.**	14
Number of single resident cells, rooms, or other enclosures:	0
Number of multiple occupancy cells, rooms, or other enclosures:	0
Number of open bay/dorm housing units:	14
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	☒ Yes ☐ No
Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	☐ Yes ☒ No

Medical and Mental Health Services and Forensic Medical Exams	
Are medical services provided on-site?	☒ Yes ☐ No
Are mental health services provided on-site?	☒ Yes ☐ No
Where are sexual assault forensic medical exams provided? Select all that apply.	☐ On-site ☒ Local hospital/clinic ☐ Rape Crisis Center ☐ Other (please name or describe: Click or tap here to enter text.)

Investigations	
Criminal Investigations	
Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:	0
When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.	☐ Facility investigators ☐ Agency investigators ☒ An external investigative entity
Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)	☒ Local police department ☐ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☐ Other (please name or describe: Click or tap here to enter text.) ☐ N/A
Administrative Investigations	
Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?	3
When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: Select all that apply	☒ Facility investigators ☐ Agency investigators ☒ An external investigative entity
Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)	☒ Local police department ☐ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☐ Other (please name or describe: Click or tap here to enter text.) ☐ N/A

Audit Findings

Audit Narrative

The Prison Rape Elimination Act (PREA) certification audit for the Travis County SMART Program, under the jurisdiction of the Travis County Community Justice Services and the Texas Department of Criminal Justice, in Austin, Texas was conducted on December 18-19, 2019, to determine the compliance of the Prison Rape Elimination Act Standards. The audit was conducted by Kendra Prisk, United States Department of Justice (DOJ) Prison Rape Elimination Act Certified Auditor.

The auditor conducted the audit through a third-party entity as a contractor and is personally accountable for complying with the DOJ certification requirements and audit findings. The agency contract was secured through a third-party entity, PREA Auditors of America, LLC. and not directly by the auditor herself. The contract described the specific work required according to the DOJ standards and PREA audit handbook to include the pre-audit, onsite audit and post-audit.

Prior to the on-site audit the auditor reviewed the Pre-Audit Questionnaire (PAQ) and supporting documentation. The facility was very responsive related to any questions the auditor had during this review. The Director ensured the audit posting was placed throughout the facility prior to the audit. The Director provided documentation certifying that the PREA audit announcement was posted in the housing units at the facility six weeks prior to the audit. The auditor received one letter from a resident which indicated that he was part of an initial group of men that helped educate others on PREA when it was first released.

The auditor requested the below list of residents to be available for interview selection on the first day of the on-site audit. Based on the population on the day of the audit (106) the PREA auditor handbook indicated that at least 20 residents were required to be interviewed. The auditor was unable to interview ten targeted residents as there were not ten available that fit the criteria; therefore, twelve random interviews were conducted instead of ten. From the provided lists, the auditor selected a representative sample of residents for the targeted and random interviews. Residents for the random resident interviews were chosen at random and varied across; gender, race, ethnicity, housing assignments and time in custody. Residents selected for the targeted interviews were selected across varying factors, when possible. Interviews were conducted using the *Resident Interview Questionnaire* supplemented by the *Targeted Resident Questionnaires*. The table following the resident listings depicts the breakdown of resident interviews.

1. Complete resident roster (provided based on actual population on the first day of the on-site portion of the audit)
2. Residents with disabilities (i.e. physical disabilities, blind, deaf, hard of hearing, cognitive disabilities)
3. Residents who are Limited English Proficient (LEP)
4. Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) residents
5. Residents who reported sexual abuse

Category of Residents	Number of Interviews
Random Residents	12
Targeted Residents	8
Total Residents Interviewed	20
Targeted Residents Interview:	
• Residents with a Disability	1
• Residents who are LEP	0
• Residents with a Cognitive Disability	0
• Residents who Identify as Lesbian, Gay or Bisexual	5
• Residents who Identify as Transgender or Intersex	1
• Residents who Reported Sexual Abuse	1[1]

The auditor requested the below listing of staff to be available for interview selection on the first day of the on-site audit. Staff interviews were conducted in accordance with the PREA auditor handbook. The handbook indicated that at least twelve randomly selected staff were required to be interviewed as well as specialized staff. From the provided lists, the auditor selected a representative sample of staff for the specialized and random interviews. Staff for the random interviews were chosen at random and varied across; gender, race, ethnicity and post assignments. Staff selected for the specialized interviews were selected at random across varying factors, when possible. Staff from all three shifts were interviewed. Interviews were conducted using the *Interview Guide for a Random Sample of Staff* supplemented by the *Interview Guide for Specialized Staff.* The table following the staff listings depicts the breakdown of staff interviews.

1. Complete staff roster (indicating title, shift and post assignment)
2. Specialized staff which includes:
    - Agency contract administrator
    - Medical staff/Mental Health staff
    - Administrative (Human Resources) staff
    - SAFE and/or SANE staff
    - Volunteers who have contact with residents
    - Contractors who have contact with residents
    - Investigative staff
    - Staff who perform screening for risk of victimization and abusiveness

[1] It should be noted that the auditor interviewed a resident who reported sexual harassment with the "reported sexual abuse" interview questions, however numerous did not apply or were not applicable.

- Staff on the sexual abuse incident review team
- Designated staff member charged with monitoring retaliation
- First responders, security staff (individuals who have responded to an incident of sexual abuse) and non-security staff
- Intake staff

Category of Staff	Number of Interviews
Random Staff	12
Specialized Staff	12
Total Staff Interviews	24
Specialized Staff Interviews	
• Contract Administrator	1
• Medical and Mental Health Staff	0
• Human Resources Staff	1
• Volunteers and Contractors	2
• Investigative Staff	2
• Staff who Perform Screening for Risk of Victimization	1
• Incident Review Team	1
• Designated Staff Member Charged with Monitoring Retaliation	1
• Security and Non-Security who Acted as First Responders	2
• Intake Staff	1

It should be noted that the Austin Police Department conducts criminal investigation and were unable to be interviewed. Additionally, SANE/SAFE staff are employed by the local hospital and as such were not able to be interviewed. All 30 security staff members are considered contractors as they work for Gateway Foundation and are not directly employed by Travis County SMART. The auditor attempted to contact SAFE Alliance on three separate occasions but was unable to speak to someone to conduct an interview related to advocacy services.

The auditor also conducted interviews with the below leadership staff (not counted in table above):

- Ms. Margie Kanada (Agency Head Designee)
- Mr. Dave Terronez (Facility Director)
- Mr. Enrique Covarrubias (PREA Coordinator “PC”)

The on-site portion of the audit was conducted on December 18, 2019 and December 19, 2019. The auditor had an initial briefing with leadership staff. After the initial briefing, the auditor reviewed documentation and completed several of the specialized staff interviews. A tour of the facility was conducted in the afternoon at 4:00pm. The tour including all areas associated with the Travis County SMART Facility, to include, buildings A, B and C. During the tour the auditor was cognizant of staffing levels, video monitoring placement, blind spots, posted PREA information, cross-gender announcements, privacy for residents in bathroom/shower areas and other factors as indicated in the below standard findings. The auditor confirmed that the audit announcement was posted throughout the facility with the dates of the audit and auditor contact information. During the tour the auditor spoke to staff and residents informally about PREA and the facility in general. The tour was completed at 4:45pm.

Interviews were conducted on December 18, 2019 in the afternoon and December 19, 2019. During the audit the auditor requested personnel and training files of staff, resident files, grievances, incident reports medical and mental health documents and investigative files for review. A more detailed description of the documentation review is as follows:

Personnel and Training Files. The facility has 50 staff assigned. The auditor reviewed a random sample of twelve personnel and training records that included five individuals hired within the past twelve months. The sample included a variety of job functions and post assignments, including both supervisory and line staff. Additionally, personnel and training files for five volunteer and ten contractors at the facility were reviewed. It should be noted that all security staff are considered contractors as they work for the Gateway Foundation. Personnel and training files were selected for those staff that the auditor conducted random interviews with and as such the files selected were an unbiased random sample.

Resident Files. On the first day of the onsite phase of the audit, the resident population was 106. A total of 20 resident records were reviewed. The records reviewed were of those residents selected to be interviewed via the random resident selection and the targeted resident selection. The resident files contained documentation of resident PREA education, the PREA risk screening and the PREA risk screening re-assessment.

Medical and Mental Health Records. The auditor reviewed three records of residents who reported sexual abuse. A review of the medical records indicated that none of the allegations rose to the level of requiring medical attention, however all were seen by mental health. A review of the mental health records indicated that all three sexual abuse victims were seen by mental health within seven days of the reported allegations.

Grievances. In the past year, the facility had not received any grievances involving sexual abuse or sexual harassment. The auditor reviewed a sample of ten grievances for the previous twelve months. The review indicated that no sexual abuse or sexual harassment grievance were received by the facility in the previous twelve months.

Incident Reports. The facility indicated that there were sixteen sexual abuse or sexual harassment incidents reported in the previous twelve months. All incidents reports related to those allegations were reviewed.

Investigation Files. During the previous twelve months, there were sixteen allegations (there was one allegation that had an administrative and criminal investigation completed) reported. The auditor reviewed all of the investigative reports to ensure all components were included. It should be noted that after a review of the allegations, the auditor determined that eight allegations were not PREA allegations as they did not rise to the level of PREA; four were not repeated, two were related to official duties and two did not meet the PREA definition. All allegations, whether they rose to the level of PREA or not, were reported and investigated. The investigations included a section of any corrective action and recommendations.

	Sexual Abuse		Sexual Harassment	
	Resident on Resident	Staff on Resident	Resident on Resident	Staff on Resident
Substantiated	1	0	2	0
Unsubstantiated	0	0	3	0
Unfounded	2	0	0	0
Total Allegations	3	0	5	0

Facility Characteristics

The Travis County SMART Facility is a Community Corrections Facility under the authority of the Travis County Community Justice Services and the Texas Department of Criminal Justice. Travis County SMART is located at, 3404 FM 973, Del Valle, Texas. Travis SMART is located East of Austin-Bergstrom International Airport. The facility is a substance abuse treatment facility that utilizes Cognitive Behavioral Intervention (CBI). CBI is a therapeutic approach designed to address psychological problems at the cognitive level, through activation and analysis of thoughts, experiences, memories and senses. The facility offers two program “tracks”, one that is thirteen weeks and the other that is 20 weeks. Each resident must complete their track prior to being discharged from the facility. After residents complete the program, they are transferred to a specialized supervision unit where they complete a six month track for after care.

The facility consists of the two buildings (“A” and “B”); however, the second building has an extended hallway that leads to what they refer to as Building “C”. Building “C” is not physically separate from Building “B” and as such there are only two physically separate building. Additionally, there are two sheds on the property, one is utilized for storage and the other for maintenance equipment, neither of these sheds are accessed by residents. Building “A” consists of female residents while Building “B” consists of male residents. Both buildings have an area separate from the resident areas where administrative offices are located. Building “A” consists of four dorms, a cafeteria, a food serving room, a medical room and numerous other rooms utilized for GED, library, programs and groups. A courtyard is located outside of the cafeteria in Building “A” for the female residents to utilize. Building “B” consist of five dorms, a cafeteria, a kitchen, a laundry area and numerous other rooms utilized for library, programs and groups.

The outdoor recreation area is shared by both buildings and is located behind (South) Building “B”. The outdoor recreation area includes a space to play basketball, a space to play volleyball and an area with pavilions to sit and socialize. The total capacity for the facility is 116. On the first day of the audit the population at the facility was 106. The facility houses adult male and adult female residents. The age range of the facility’s population is 18-99 years of age. The average length of stay for residents at the facility is thirteen or 20 weeks. The maximum time a resident can stay at the facility is two years.

Building “A” comprises six housing areas (only four are currently being utilized) which are referred to as dorms. The dorms are labeled by number (1-4). All dorms comprise general population residents with the same housing and custody levels. Two dorms are located on the Northwest side of the building and four dorms are located on the Southwest side of the building. All dorms are equipped with video monitoring in the bedding and dayroom/tv area. A breakdown of the dorms and the resident population that make up each dorm is found below. Of the four dorms, all are open bay style with a capacity of ten.

The dorms contain the resident bedding area, bathroom area and dayroom/tv area. The bedding area consists of groups of beds (some single and some bunk bed style) in an open area. The bathroom area is separate from the living area in the room. It is separated by a wall and has an entrance with a shower curtain. The bathroom consists of showers, toilets and sinks in a locker room style set up. The showers are single person showers and each shower has a curtain. Each toilet is enclosed with walls and a door and provides adequate privacy for the residents. The dayroom/tv area is near the bedding area. The space has tables and chairs to allow for the resident to watch tv and socialize. The dayroom area is equipped with a washer and dryer for the resident to utilize. The entrance doors to the dorms have a small window to allow staff to monitor the safety of the residents. Staff conduct count three times per shift in the dorms. PREA posters in bright colors were displayed throughout the facility, including in each dorm.

Building “B” comprises five housing areas, which are referred to as dorms. The dorms are labeled by number (10-14). All dorms comprise general population residents with the same housing and custody levels. Two dorms are located on the Southwest side of the building and three are located on the Southeast side of the building. All dorms are equipped with video monitoring in the bedding and dayroom/tv area. A breakdown of the dorms and the resident population that make up each dorm is found below. Of the five dorms, all are open bay style with a capacity of ten, fourteen or 24. Building “B” does have one segregation room that can be utilized for emergency situations and to temporarily separate a resident from the other.

The dorms contain the resident bedding area, bathroom area and dayroom/tv area. The bedding area consists of groups of beds (some single but most bunk bed style) in an open area. The bathroom area is separate from the living area in the room. It is separated by a wall and has an entrance with a shower curtain. The bathroom consists of showers, toilets and sinks in a locker room style set up. The showers are single person showers and each shower has a curtain. Each toilet is enclosed with walls and a door and provides adequate privacy for the residents. The dayroom/tv area is near the bedding area. The space has tables and chairs to allow for the resident to watch tv and socialize. All dorms were equipped with PREA posters in bright colors.

Room	Capacity	Style	Resident Population
1	10	Open Bay	Female Residents – Building A
2	10	Open Bay	Female Residents – Building A

3	10	Open Bay	Female Residents – Building A
4	10	Open Bay	Female Residents – Building A
5	10	Open Bay	Vacant (Female Residents) – Building A
6	10	Open Bay	Vacant (Female Residents) – Building A
10	10	Open Bay	Male Residents – Building B
11	10	Open Bay	Male Residents – Building B
12	24	Open Bay	Male Residents – Building B
13	24	Open Bay	Male Residents – Building B
14	24	Open Bay	Male Residents – Building B

In addition to the housing units, Building “A” consists of a cafeteria, a food serving area, a medical exam room, numerous group rooms, a GED room, a library, an area for phone calls and an outside courtyard. The entrance to Building “A” is on the West side of the building. Upon entrance you find a control station where the Direct Care Monitors are located. South of the control station is an area where residents are able to utilize the telephones. The open area consists of a row of phones and chairs for those residents who are waiting. To the East of the control station is the cafeteria. This is an open area with folding tables and chairs where residents eat meals. When not utilized for meals, the cafeteria serves other purposes, including a visitation area, an indoor recreation area and a programming area. There is not a kitchen in Building “A”, as all food is prepared in Building “B” and transported over to Building “A”. There is a small preparation room to the East of the cafeteria where residents are able to keep the food warm and prepare the trays for serving. Both the cafeteria and the food serving area are equipped with video monitoring technology (three cameras). To the South of the cafeteria is an outdoor courtyard for the residents. This is an enclosed grassy area with benches. To the North of the cafeteria is the medical room. The facility provides only basic medical care and medication distribution for residents and anything advanced requires the resident to be transported to the local hospital. The facility employs three medical nurses per day that are at the facility during normal business hours. A doctor comes to the facility once a week (Tuesdays) to conduct assessments on new residents. In the Southwest hallway, where four dorms are located, are additional dorms that have been converted into group rooms. There are numerous vacant rooms that are not utilized or are utilized for storage. One room is utilized as a GED room, another is utilized as a library and a few are utilized as programming group rooms. All rooms are equipped with video monitoring technology and are not accessible to the residents without a staff member. In the Northwest hallway, where two dorms are located, there is also a vacant room that is utilized as a group room. Building “A” also contains a plethora of administrative offices. They are located on the East side of the building an make up the entire length of the East side hallway.

A parking lot separates Building “A” from Building “B”. Outside of Building “B” to the South is the outdoor recreation area. This area is shared by all residents, however male and female residents have different days and times of use so as to ensure separation. The outdoor recreation area is equipped with a basketball court, a sand volleyball court and numerous pavilions and benches.

In addition to the housing units, Building “B” consists of a cafeteria, a kitchen, a nurse’s station, numerous group rooms, a library, a laundry room, two areas for phone calls and an outside courtyard. The entrance to Building “B” is on the North side of the building. Upon entrance you find a lobby area that has access

on the West side to the hallway that leads to what is referred to as Building “C”. This hallway consists of administrative offices. Straight through the lobby (South) you find the control station where the Direct Care Monitors are located. To the East and West of the control station are two hallways where residents are able to utilize the telephones. To the East of the control station is the cafeteria and kitchen. This is an open area with folding tables and chairs where residents eat meals. When not utilized for meals, the cafeteria serves other purposes, including a visitation area, an indoor recreation area and a programming area. The kitchen is directly off the cafeteria and consists of all equipment and supplies to prepare and cook meals. Both the cafeteria and the kitchen are equipped with video monitoring technology (eight cameras). In the West hallway you will find the nurse’s station, which is where residents go to receive medication. Additionally, there are two dorms, a group room and a courtyard located off the West hallway. The outdoor courtyard is an enclosed grassy area with benches. In the East hallway there are three dorms, additional group rooms, a library and a laundry area that consists of washers and dryers. All rooms are equipped with video monitoring technology and are not accessible to the residents without a staff member.

Building “C”, as indicated is located to the West of Building “B” lobby. This area as indicated above has a hallway full of administrative office. At the end of the hallway is another hallway that goes North and makes an “L” shape. This area is utilized for the aftercare staff administrative offices. Residents who complete the program are required to complete an aftercare program in the community. This involves coming to the building to receive services and check in with staff. The Facility Director indicated that these individuals are not under any confinement setting, but rather live in the community. These individuals may or may not have been involved in the Travis County SMART program. The Director indicated that the aftercare program was in the process of relocating to a different location and would not be in Building “C” much longer.

The facility employs 50 staff, 30 Gateway security staff and 20 SMART staff. Security staff make up three shifts; first shift works from 6:00am-2:00pm, second shift works from 2:00pm-10:00pm and third shift works from 10:00pm-6:00am. Each shift has one supervisor responsible for operations. First and second shift have five additional staff, while third shift has four additional staff. Building “A” requires only female staff while Building “B” allows for female and male staff, with at least one male staff member required per shift. SMART staff serve as counselors, probation officers, medical staff and administrative staff. The facility employs one additional contractor in addition to Gateway employees, who provides mental health services for the residents. Additionally, the facility has eight volunteers that provide services to the residents.

Summary of Audit Findings

Standards Exceeded

Number of Standards Exceeded: 0
List of Standards Exceeded: NA

Standards Met

Number of Standards Met: 41

Standards Not Met

Number of Standards Not Met: 0
List of Standards Not Met: N/A

PREVENTION PLANNING

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

115.211 (a)

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

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

115.211 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator? ☒ Yes ☐ No

- Is the PREA Coordinator position in the upper-level of the agency hierarchy? ☒ Yes ☐ No

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

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Zero Tolerance and PREA Coordinator Policy
3. Definitions Policy
4. Organizational Chart

Interviews:

1. Interview with the PREA Coordinator

Findings (By Provision):

115.211 (a): The agency has numerous policies[2] that when combined equal a comprehensive PREA policy. They outline the agencies prevention, detection and response. The agency has a zero-tolerance policy towards all forms of sexual abuse and sexual harassment. Agency policies addresses "Preventing" sexual abuse and sexual harassment through the designation of a PC, criminal history background checks (staff, volunteers and contractors), training (staff, volunteers and contractors), staffing, intake/risk screening, resident education and posting of signage (PREA posters, etc.). The policies address "Detecting" sexual abuse and sexual harassment through training (staff, volunteers, and contractors), and intake/risk screening. The policies address "Responding" to allegations of sexual abuse and sexual harassment through reporting, investigations, victim services, medical and mental health services, disciplinary sanctions for staff and residents (including notification of licensing agencies), incident reviews and data collection. These policies are consistent with PREA standards and outline the agency's approach to sexual safety.

115.211 (b): The agency's organizational chart reflects that the PC position is an upper-level position and is agency-wide. The PC is the Treatment and Assessment Division Director who reports to the Agency Director. The PC was interviewed and he reported that his primary job responsibility is PREA compliance and he has adequate time to coordinate these efforts. He stated that he has direct access modify any policies and practices to ensure sexual safety. During the site review, the PC demonstrated knowledge of the agency policies and practices designed to promote sexual safety in the facility.

The evidence shows that the agency has PREA policies, has designated an upper-level, agency-wide PC as verified through the organizational chart. Based on the review of the PAQ and related documents, PREA implementation appears to comply with the standard under the PC. The preparedness for the audit and overall incorporation of institutionalized sexual safety practices demonstrates that the PC has sufficient time and authority to accomplish PREA responsibilities for the agency and facility.

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

115.212 (a)

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

115.212 (b)

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

[2] It should be noted each of these policies was not listed in the above documents as each standard has its own policy and as such would be too many to list. The policies that correspond to each prevention, detection and response piece are found under each applicable standard.

115.212 (c)

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

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

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Administrative Directive AD-02.46 (TDCJ)
3. Contracting with Other Entities for Confinement of Residents Policy
4. TDCJ Contracts

Interviews:

1. Interview with the Agency's Contract Administrator

Findings (By Provision):

115.212 (a): The parent agency (the Texas Department of Criminal Justice) has 28 contracts related to the confinement of residents/residents; eleven secure, eight re-entry and nine transitional treatment. TDCJ AD-02.46 as well as the facilities policy on Contracting with Other Entities for Confinement of Residents requires all contracts to comply with all applicable TDCJ policies and procedures and PREA standards. A review of the 28 contracts confirmed that all had language requiring compliance with PREA standards (either directly stated PREA compliance or via compliance with department policy and/or federal law). The interview with the TDCJ Contract Administrator indicated that all contracts have a contract monitor to ensure contract compliance. The Contract Administrator indicated that all contracts have PREA compliance language and that the contract monitor ensures compliance with PREA standards. Additionally, the facility does not contract with any other entities for the confinement of their residents.

115.212 (b): The parent agency (the Texas Department of Criminal Justice) has 28 contracts related to the confinement of residents/residents; eleven secure, eight re-entry and nine transitional treatment. TDCJ AD-02.46 as well as the facilities policy on Contracting with Other Entities for Confinement of

Residents requires all contracts to comply with all applicable TDCJ policies and procedures and PREA standards. A review of the 28 contracts confirmed that all had language requiring compliance with PREA standards (either directly stated PREA compliance or via compliance with department policy and/or federal law). The interview with the TDCJ Contract Administrator indicated that all contracts have a contract monitor to ensure contract compliance. The Contract Administrator indicated that all contracts have PREA compliance language and that the contract monitor ensures compliance with PREA standards. Additionally, the facility does not contract with any other entities for the confinement of their residents.

115.212 (c): The parent agency (the Texas Department of Criminal Justice) has 28 contracts related to the confinement of residents/residents; eleven secure, eight re-entry and nine transitional treatment. TDCJ AD-02.46 as well as the facilities policy on Contracting with Other Entities for Confinement of Residents requires all contracts to comply with all applicable TDCJ policies and procedures and PREA standards. A review of the 28 contracts confirmed that all had language requiring compliance with PREA standards (either directly stated PREA compliance or via compliance with department policy and/or federal law). The interview with the TDCJ Contract Administrator indicated that all contracts have a contract monitor to ensure contract compliance. The Contract Administrator indicated that all contracts have PREA compliance language and that the contract monitor ensures compliance with PREA standards. Additionally, the facility does not contract with any other entities for the confinement of their residents.

Based on the review of the PAQ, TDCJ's Administrative Directive AD-02.46, Travis County's policy on Contracting with Other Entities for Confinement of Residents, a review of TDCJ's 28 contracts and the interview with the TDCJ's Contract Administrator, this standard appears to be compliant.

Standard 115.213: Supervision and monitoring

115.213 (a)

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

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

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

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The prevalence of substantiated and unsubstantiated incidents of sexual abuse? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors? ☒ Yes ☐ No

115.213 (b)

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

115.213 (c)

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

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

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

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

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Supervision and Monitoring Policy
3. Staffing Plan

Interviews:

1. Interview with the Facility Director
2. Interview with the PREA Coordinator

Site Review Observations:

1. Staffing Levels

Findings (By Provision):

115.213 (a): The Supervision and Monitoring Policy indicates that the staffing plan was developed to provide expected levels of program supervision and monitoring to ensure the facility is safe and secure. The staffing plan takes into consideration; the physical layout of each facility; the composition of the

resident population; the prevalence of substantiated and unsubstantiated incident of abuse and any other relevant factors. The current staffing plan was reviewed and indicated that staffing was based off the facility's maximum capacity (116). First and second shift each have five Direct Care Monitors (DCM) and one lead DCM. Additionally, first shift has one part time DCM and one part time driver while second shift has two part time DCMs and a Supervisor. Third shift has four DCMs and a lead DCM. Additionally, third shift has one part time DCM and one Supervisor. In addition to DCMs there are also two Residential Supervisors assigned to each building per shift. Interviews with the Facility Director and the PC confirmed that the facility has a staffing plan that provides adequate staffing levels and that they comply with the plan on a regular basis. The PC confirmed that they monitor the ratio of residents in each building and staff accordingly. During the tour the auditor observed that staff were present in each dorm and conducting rounds to monitor the residents.

115.213 (b): The facility indicated in the PAQ that no deviations from the staffing plan had occurred in the previous twelve months. The Supervision and Monitoring Policy indicated that all deviations from the staffing plan are required to be documented by the Facility Administrator and forwarded to the PREA Coordinator within seven days. The interview with the Facility Director indicated that all deviations are documented on the management meeting minutes.

115.213 (c): The staffing plan was reviewed on November 5, 2019. The plan was reviewed to assess, determine and document whether any adjustments were needed to the staffing plan; the prevailing staffing patterns; the facility's deployment of video monitoring technologies and the resources the facility had available to commit to ensuring adherence to the staffing plan. The Supervision and Monitoring Policy describes the required annual review. The PC confirmed in the interview that the review is completed annually and that leadership assesses, determines and documents whether adjustments are necessary.

Based on a review of the PAQ, the Supervision and Monitoring Policy, the staffing plan, observations made during the tour by the auditor that confirmed staffing levels were adequate and staff were visible in both building for supervision, monitoring and deterrence and interviews with the PC and Facility Director, this standard appears to be compliant.

Standard 115.215: Limits to cross-gender viewing and searches

115.215 (a)

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

115.215 (b)

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

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

115.215 (c)

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

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

115.215 (d)

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

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

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

115.215 (e)

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

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

115.215 (f)

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

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

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Limits to Cross Gender Viewing and Searches Procedure
3. Gateway Procedure – PS 120

Interviews:

1. Interview with Random Staff
2. Interview with Random Residents
3. Interview with Transgender/Intersex Residents

Site Review Observations:

1. Observations of Bathroom and Shower Areas
2. Observation of Cross Gender Announcement

Findings (By Provision):

115.215 (a): The Limits to Cross Gender Viewing and Searches Policy prohibit staff from conducting cross gender strip searches and cross gender body cavity searches except in exigent circumstances. The PAQ indicated that no searches of this kind were conducted at the facility over the past twelve months and that the facility does not conduct these types of searches in general. Interviews with staff indicated that residents are not strip searched at the facility. Interviews with residents indicated that none had been naked in front of staff of the opposite gender.

115.215 (b): The Limits to Cross Gender Viewing and Searches policy indicated that the facility does not conduct pat-down searches of any resident. Interviews with staff indicated that the facility does not perform pat-down searches of residents. Interviews with female residents indicated that they were not subjected to pat-down searches of any kind and they were never prohibited from programs or activities because a female staff member was not available for a search.

115.215 (c): The Limits to Cross Gender Viewing and Searches Policy requires staff to document all cross-gender strip searches and cross gender visual body cavity searches. The facility does not conduct pat-down searches of male or female residents and as such none were documented. The PAQ indicated that no cross-gender searches or pat-down searches have been conducted in the previous twelve months.

115.215 (d): The Limits to Cross Gender Viewing and Searches Policy, indicates that the facility enables residents to shower, perform bodily functions and change clothes without staff of the opposite gender viewing their breasts, buttocks or genitalia. Additionally, the policy requires staff of the opposite gender to announce their presence prior to entering a housing unit. Interviews with random residents and interviews with random staff indicated that residents have privacy when showering, using the restroom and changing clothes via solid doors and shower curtains. Interviews also confirm that staff of the opposite gender announce their presence when entering a housing unit. During the tour, the auditor observed that staff knocked on the dorm doors and announced “male” or “female” prior to entering. The

auditor observed that all dorms had a shower curtain at the entrance to the bathroom. The toilets were enclosed with a door for privacy. The showers all were equipped with shower curtains and had walls as dividers.

115.215 (e): The Limits to Cross Gender Viewing and Searches Policy, prohibits staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. The PAQ indicated that there had been no searches of this nature within the past twelve months. All staff interviewed indicated that they were not authorized to perform any searches, much less this type of search. Staff indicated this was against policy and that medical would be responsible for anything related to the topic. The interview with transgender resident indicated that the resident was never searched for this purpose and that the resident did not feel she was placed in a specific dorm due to her gender identity.

115.215 (f): The Limits to Cross Gender Viewing and Searches Policy indicates that security staff do not conduct pat searches of any kind and as such do not receive training. Interviews with a random sample of staff indicated that they are not authorized to conduct pat-down searches of any resident.

Based on a review of the PAQ, the Limits to Cross Gender Viewing and Searches Policy, the Gateway Procedure – PS 120, observations made with regard to the opposite gender announcement, privacy for residents when showering, using the restroom and changing clothes and interviews with residents and staff, this standard appears to be compliant.

Recommendation:

While a policy is in place indicating that pat searches are not conducted by facility staff. The Gateway policy on searches indicates that strip searches can in fact take place. The policy states: "the search will consist of the client removing their clothing down to their undergarments. If there is reasonable suspicion that the client is attempting to smuggle contraband into the facility, they may undergo strip searches. Sites and/or programs may elect to conduct strip searches for all clients". Due to the possibility of strip searches being conducted, staff should be provided training on how to conduct these types of searches of transgender and intersex residents in a professional and respectful manner. The auditor recommends that the facility create or obtain a training curriculum for professional and respectful searches of transgender and intersex residents and train all current and future staff.

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

115.216 (a)

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

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

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

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

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

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

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

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

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

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

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

115.216 (b)

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

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

115.216 (c)

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

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Residents with Disabilities and Residents who are Limited English Proficient Policy
3. PREA Posters
4. List of Staff Translators

Interviews:

1. Interview with the Agency Head Designee
2. Interview with Residents with Disabilities

Site Review Observations:

1. Observations of PREA Posters

Findings (By Provision):

115.216 (a): The Residents with Disabilities and Residents who are Limited English Proficient Policy establishes the procedure to provide disabled residents an equal opportunity to benefit from all the aspects of the facility's efforts to prevent, detect and respond to sexual abuse and sexual harassment. Policy indicates that auxiliary aides are provided for residents with hearing impairments, resident who have difficulty understanding will have information communicated to them on an individual basis and interpreters are available for any resident who is LEP. Additionally, the policy indicates that a counselor is available for residents with limited reading or writing skills. Documents were reviewed and are available in Spanish and large size fonts if needed. The Interview with the Agency Head Designee indicated the facility would utilize a staff member to translate and auxiliary aids would be provided for any resident who needed assistance. The interview with the disabled resident indicated he receive PREA information in a format that he understood. During the tour, the PREA signage was observed to be in large text and in bright colors.

115.216 (b): The Residents with Disabilities and Residents who are Limited English Proficient Policy establishes the procedure to ensure meaningful access to all the aspects of the facility's efforts to prevent,

detect and respond to sexual abuse and sexual harassment to residents who are Limited English Proficient (LEP). Policy and interviews indicate that the agency's PREA information is available in numerous formats to include; written, English, Spanish, large font, etc. The Interview with the Agency Head Designee indicated the facility would utilize staff members to assist with any interpretation issues. The facility did not currently house any LEP inmates. This was confirmed through documentation review and during the tour.

115.216 (c): The Residents with Disabilities and Residents who are Limited English Proficient Policy prohibits the use of resident interpreters, readers or any other type of resident assistants for allegations of sexual abuse and sexual harassment, except in limited circumstances. The PAQ indicated that there were no instances where a resident was utilized. Interviews with a random sample of staff indicated that eleven of the twelve staff advised that residents are not utilized to translate for PREA purposes. The interview with the disabled resident indicated that another resident was not utilized to assist him.

Based on a review of the PAQ, the Residents with Disabilities and Residents who are Limited English Proficient Policy, a list of staff translators, observations made during the tour to include the PREA signage as well as interviews with the Agency Head Designee and a disabled resident indicates that this standard appears to be compliant.

Standard 115.217: Hiring and promotion decisions

115.217 (a)

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

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

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

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

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

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

115.217 (b)

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

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

115.217 (c)

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

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

115.217 (d)

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

115.217 (e)

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

115.217 (f)

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

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

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

115.217 (g)

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

115.217 (h)

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

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Hiring and Promotions Decision Policy
3. Application for Staff Access to Residential Facilities Form
4. Personnel Files of Staff
5. Contractor Background Files

Interviews:

1. Interview with Human Resource Staff

Site Review Observations:

1. Review of Employee Personnel Files
2. Review of Contractor Personnel Files

Findings (By Provision):

115.217 (a): The Hiring and Promotions Decision Policy indicates that the facility will not hire or promote anyone who may come in contact with residents, and shall not enlist the services of any contractor who may have contact with residents if they have: engaged in sexual abuse in prison, jail, lockup or any other institution; been convicted of engaging or attempting to engage in sexual activity in the community or has been civilly or administratively adjudicated to have engaged in sexual abuse by force, overt or implied threats of force or coercion. The policy indicates staff are required to complete the Employment Application Supplement that includes questions related to sexual abuse and sexual harassment. A review of personnel files of staff indicated that all staff and contractors have a criminal background completed prior to being authorized to work at the facility. Of the five files reviewed of staff hired in the previous twelve months, zero indicated they were asked about the questions referenced above. The interview with that Human Resource staff member as well as the Facility Director and PC indicated that these questions and institutional checks were not conducted until approximately a month ago. The agency was unaware

this was a requirement, but as soon as they became aware, they added the questions to the Application for Staff Access to Residential Facilities Form. Additionally, they went back through all current staff and had them complete a form related to any previous institutional employment, and plan to have these all checked by January 31, 2020.

115.217 (b): The Hiring and Promotions Decision Policy indicates that the agency considers any incidents of sexual harassment in determining whether to hire or promote any staff or enlist the services of any contractor who may have contact with an resident. Human Resource staff indicated that sexual harassment is considered when hiring or promoting staff or enlisting services of any contractors.

115.217 (c): The Hiring and Promotions Decision Policy indicates that the agency is required to perform criminal background checks and make its best effort to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignations during a pending investigation of sexual abuse for new employees that may have contact with residents. The PAQ indicated that 100% (50 staff members) of those hired in the past twelve months that may have contact with residents had received a criminal background check. A review of personnel files indicated 100% of the random sample reviewed (five hired in the previous twelve months) had a criminal background completed via the National Crime Information Center (NCIC) and Texas Crime Information Center (TCIC) queries. The interviews with the Human Resource staff member indicated that all staff receive a criminal background check prior to employment. Interviews with the Human Resource staff member, as well as the Facility Director and PC indicated that institutional checks were not conducted until approximately a month ago as they were unaware of this requirement. The section has subsequently been added to the Application for Staff Access to Residential Facilities Form. Additionally, Human Resource staff went back through all current staff and had them complete a form related to any previous institutional employment. They plan to have these all checked by January 31, 2020. Based on this information this provision of the standard requires corrective action.

115.217 (d): The Hiring and Promotions Decision Policy indicates that the agency performs criminal background checks before enlisting the services of any contractor who may have contact with residents. The PAQ indicated that there has been one contract at the facility within the past twelve months. The contract is with a staff member who provides mental health services. During the on-site portion of the audit it was clarified that there are actually 31 contracts as all security staff are employed with the Gateway Foundation are considered contractors. Of the eight Gateway staff files that were reviewed and the mental health contracted staff member file, 100% have had a criminal background check prior to enlisting services. Human Resource staff indicated that all contractors have a criminal background check completed prior to working at the facility.

115.217 (e): The Hiring and Promotions Decision Policy indicates that all employees and contractors are required to have an annual background check. This background check is completed based on the individual's hire date. Criminal background checks are conducted using the National Crime Information Center (NCIC) and Texas Crime Information Center (TCIC) queries. All twelve staff reviewed had a criminal background check conducted within the previous twelve months, most were completed in May 2019. It should be noted that the National Crime Information Center (NCIC) and Texas Crime Information Center (TCIC) criminal background query documents are destroyed annually when an updated background check is completed as required by law. The interview with Human Resource staff confirmed that all staff and contractors receive a criminal background check annually.

115.217 (f): The Hiring and Promotions Decision Policy indicates that the agency will ask all applicants and employees who have contact with residents directly about whether they have: engaged in sexual abuse in prison, jail, lockup or any other institution been convicted of engaging or attempting to engage

in sexual activity in the community or has been civilly or administratively adjudicated to have engaged in sexual abuse by force, overt or implied threats of force or coercion through a written application, during any interviews or through any written self-evaluations as part of a review of current employees. The policy indicates staff are required to complete the Employment Application Supplement that includes questions related to sexual abuse and sexual harassment. A review of personnel files of the five staff hired in the previous twelve months indicated zero were asked about the questions referenced in section (a). The interview with that Human Resource staff member as well as the Facility Director and PC indicated that these questions were not asked or inquired about in the hiring process until approximately a month ago. The agency was unaware this was a requirement, but as soon as they became aware, they added the questions to the Application for Staff Access to Residential Facilities Form. Human Resource staff provided the auditor with 20 updated Application for Staff Access to Residential Facilities Forms dated December 2019 that showed staff answering the required questions as indicated in this provision. While a process is now in place, further evidence is required to ensure this practice is systematic. As such, this provision of the standard is not compliant and requires corrective action.

115.217 (g): The Hiring and Promotions Decision Policy indicates that material omissions regarding sexual misconduct or the provision of materially false information is grounds for termination. Additionally, the policy indicates that staff are provided the Conditions of Employment form which requires staff to have a continuing affirmative duty to disclose any sexual misconduct. Human resource staff confirm that any false information or omissions would result in an employee or contractor being terminated.

115.217 (h): The Hiring and Promotions Decision Policy indicates that the facility will provide information related to substantiated allegations of sexual abuse or sexual harassment involving a former employee to institutional employers for whom the employee has applied to work. Human resource staff indicated that this information would be provided when requested.

While provisions (a), (b), (d), (e), (g) and (h) appear to be compliant based on a review of the PAQ, the Hiring and Promotions Decision Policy, the Employment Application Supplement, the Conditions of Employment form, the Application for Staff Access to Residential Facilities Form, a review of personnel files for staff and contractors and information obtained from the Human Resource staff, provisions (c) and (f) were only recently implemented (December) and as such cannot be found compliant without additional evidence of a systemic hiring and promotions practice. As such, this standard requires corrective action. With regard to provision (c) a review of personnel files indicated no prior institutional checks were completed. Interviews with the Human Resource staff member, as well as the Facility Director and PC indicated that institutional checks were not conducted until approximately a month ago as they were unaware of this requirement. The section has subsequently been added to the Application for Staff Access to Residential Facilities Form. Additionally, Human Resource staff went back through all current staff and had them complete a form related to any previous institutional employment. They plan to have these all checked by January 31, 2020. Based on this information this provision of the standard requires corrective action. With regard to provision (f), a review of personnel files of staff hired within the previous twelve months indicated that zero were asked about the activities described in section (a). The interview with Human Resource staff as well as the interviews with the Director and PC indicated that they were just made aware of this requirement and that they just recently added these questions to the Staff Access to Residential Facilities Form. Human Resource staff provided the auditor with 20 updated Application for Staff Access to Residential Facilities Forms dated December 2019 that showed staff answering the required questions as indicated in this provision. While a process is now in place, further evidence is required to ensure this practice is systematic.

Corrective Action:

The facility must continue to utilize the updated Application for Staff Access to Residential Facilities Form for employees. The facility will need to forward the completed institutional checks to the auditor once completed at the end of January. Additionally, the facility will need to send the auditor at least five new hire examples that evidence that institutional checks were conducted and the questions in provision (a) were asked to confirm that this practice is continuing to take place and has become a systematic part of the hiring and promotional process.

Verification of Corrective Action since the Interim Audit Report

The auditor gathered and analyzed the following additional evidence provided by the facility during the corrective action period relevant to the requirements in this standard.

Additional Documents:

1. Application for Staff Access to Facilities

After the issuance of the Interim Audit Report, the auditor and the facility discussed the recommended corrective action for this standard. The auditor spoke to the PREA Coordinator and Facility Director via phone for an update regarding the implementation of the corrective action. The facility provided the auditor with thirteen current staff applications that required prior institutional reference checks. The HR Manager completed the required reference checks and indicated the verbal responses from the agencies in Section E of the application. Additionally, the HR Manager provided seven completed new hire applications which included institutional reference checks as well as the questions required in subsection (a) of this standard. Based on a review of the 20 staff applications, this process appears to be systematic and as such subsections (c) and (f) of this standard appear to be corrective. Based on this review this standard appears to now be corrected and compliant.

Standard 115.218: Upgrades to facilities and technologies

115.218 (a)

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

115.218 (b)

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

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Upgrades to Facilities and Technologies Policy
3. Building and Camera Layout

Interviews:

1. Interview with the Agency Head Designee
2. Interview with the Facility Director

Site Review Observations:

1. Observations of Absence of Modification to the Physical Plant
2. Observations of Video Monitoring Technology

Findings (By Provision):

115.218 (a): The facility has not designed, acquired or planned any expansion or modification of the existing facility. The PAQ as well as interviews with the Agency Head Designee and Facility Director confirmed there have not been any modifications to the facility since August 20, 2012. During the tour, the auditor did not observe any renovations, modifications or expansions.

115.218 (b): The facility has upgraded their video monitoring technology since August 20, 2012. The upgrades were to enhance the facilities safety and security, to include sexual safety. The PAQ as well as interviews with the Agency Head Designee and Facility Director confirmed there has been upgrades to their current video monitoring technology. During the tour, the auditor observed video monitoring technology in all housing units, many common areas and in the all the hallways.

RESPONSIVE PLANNING

Standard 115.221: Evidence protocol and forensic medical examinations

115.221 (a)

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

115.221 (b)

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

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

115.221 (c)

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

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

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

- Has the agency documented its efforts to provide SAFEs or SANEs? ☒ Yes ☐ No

115.221 (d)

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

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

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

115.221 (e)

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

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

115.221 (f)

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

115.221 (g)

- Auditor is not required to audit this provision.

115.221 (h)

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

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Evidence Protocol and Forensic Medical Examination Policy
3. Austin Police Department Agreement
4. Memorandum of Understanding (MOU) with SAFE Alliance

Interviews:

1. Interview with Random Staff
2. Interview with the PREA Coordinator
3. Interview with Residents who Reported Sexual Abuse (Sexual Harassment)

Findings (By Provision):

115.221 (a): The PAQ indicated that the facility is responsible for conducting administrative investigations while the Austin Police Department is responsible for conducting criminal investigations and some administrative investigations. The PAQ indicates that the facility and the Austin Police Department both follow a uniform evidence protocol. Interviews with random staff indicated they are aware of the uniform evidence protocol. They indicated that the Austin Police Department would be responsible for the

collection of most evidence. Staff indicated they were aware of how to preserve evidence until the Police Department arrives.

115.221 (b): The PAQ indicates the protocol was developed appropriate for youth and was adapted from the DOJ's Office of Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adult/Adolescents".

115.221 (c): The Evidence Protocol and Forensic Medical Examination Policy and the Austin Police Department Agreement indicates that residents who allege sexual abuse in a timeframe to allow for evidence collection will be transported to the local hospital for a forensic examination at no cost to the victim. The facility does not offer forensic medical examinations on-site. The PAQ indicated that during the previous twelve months, there have been zero forensic exams conducted. The PAQ did however indicate if they were completed it would be by a SANE/SAFE or a qualified medical practitioner from SAFE Alliance or the hospital. During the audit period, there was not an instance where a resident was provided a forensic medical examination so no documentation was able to be reviewed. An interview was unable to be conducted due to the SANEs/SAFEs being employed by the local hospital.

115.221 (d): The Evidence Protocol and Forensic Medical Examination Policy outlines the process for resident victim services. The policy indicates that attempts shall be made to make a victim advocate from a rape crisis center available to the offender victim. The Austin Police Department Agreement and the MOU with SAFE Alliance indicate that victim services are provided to residents who allege sexual abuse and confirm the partnership between the facility and SAFE Alliance. The resident interviewed related to reporting sexual abuse actually reported a sexual harassment allegation and as such was not required to be offered victim support services.

115.221 (e): The Evidence Protocol and Forensic Medical Examination Policy outlines the process for resident victim services. The policy indicates that attempts shall be made to make a victim advocate from a rape crisis center available to the offender victim. The Austin Police Department Agreement and the MOU with SAFE Alliance indicate that victim services are provided to residents who allege sexual abuse and confirm the partnership between the facility and SAFE Alliance.

115.221 (f): The facility is responsible for conducting administrative investigations while the Austin Police Department is responsible for conducting criminal and administrative investigations. The Agreement with the Austin Police Department indicates the Sex Crimes Unit is responsible for conducting PREA investigations. The Evidence Protocol and Forensic Medical Examination Policy indicates that the investigating agency abide by sections (a)-(f) of this standard.

115.221 (g): The facility is responsible for conducting administrative investigations while the Austin Police Department is responsible for conducting criminal and administrative investigations. No state entity or Department of Justice component is responsible for conducting investigations.

115.221 (h): A victim advocate from SAFE Alliance responds to the local hospital to accompany the victim resident during a forensic examination.

Based on a review of the PAQ, The Evidence Protocol and Forensic Medical Examination Policy, the Agreement with the Austin Police Department, the MOU with SAFE Alliance and information obtained from interviews with the PC, random staff and one resident who reported sexual harassment indicates this standard appears to be compliant.

Standard 115.222: Policies to ensure referrals of allegations for investigations

115.222 (a)

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

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

115.222 (b)

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

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

- Does the agency document all such referrals? ☒ Yes ☐ No

115.222 (c)

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

115.222 (d)

- Auditor is not required to audit this provision.

115.222 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Policies to Ensure Referral of Allegations for Investigation
3. Agreement with the Austin Police Department
4. SMART Program Brochure
5. Incident Reports
6. Investigative Reports

Interviews:

1. Interview with the Agency Head Designee
2. Interview with Investigative Staff

Findings (By Provision):

115.222 (a): The Policies to Ensure Referral of Allegations for Investigation Policy outlines the administrative and criminal investigative process. The policy indicates that the Austin Police Department will be notified following an allegation of sexual abuse. If an internal investigation (administrative only) is required, one of the three staff with the specialized training will be responsible for conducting the investigation. The PAQ indicated that the facility had sixteen allegations reported within the previous twelve months. A review of documentation showed that of the sixteen allegations, only eight rose to the level of PREA. The interview with the Agency Head Designee indicated that all allegations are investigated either administratively by a trained staff member at the facility or criminally by the Austin Police Department. The interview also indicated all facility investigators had received specialized investigator training.

115.222 (b): The Policies to Ensure Referral of Allegations for Investigation Policy and the Agreement with the Austin Police Department indicates that the Sex Crimes Unit of the Austin Police Department is the primary investigative and law enforcement entity for the facility. The facility does not currently have a website, however information related to the investigating authority is found in the facility brochure, which is available in the lobby of the facility and anytime upon request to the public.

115.222 (c): The Policies to Ensure Referral of Allegations for Investigation Policy and the Agreement with the Austin Police Department indicates that the Sex Crimes Unit of the Austin Police Department is the primary investigative and law enforcement entity for the facility. The facility does not currently have a website, however information related to the investigating authority is found in the facility brochure, which is available in the lobby of the facility and anytime upon request to the public.

115.222 (d): The facility is responsible for conducting administrative investigations while the Austin Police Department is responsible for conducting criminal and administrative investigations. No state entity is responsible for conducting investigations.

115.222 (e): The facility is responsible for conducting administrative investigations while the Austin Police Department is responsible for conducting criminal and administrative investigations. No Department of Justice component is responsible for conducting investigations.

Based on a review of the PAQ, the Policies to Ensure Referral of Allegations for Investigation Policy, the Agreement with the Austin Police Department, the SMART Program Brochure and information obtained via interviews with the Agency Head Designee and facility Investigator, this standard appears to be compliant.

TRAINING AND EDUCATION

Standard 115.231: Employee training

115.231 (a)

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in confinement? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: The common reactions of sexual abuse and sexual harassment victims? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? ☒ Yes ☐ No

115.231 (b)

- Is such training tailored to the gender of the residents at the employee's facility? ☒ Yes ☐ No

- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? ☒ Yes ☐ No

115.231 (c)

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

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

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

115.231 (d)

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

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Employee Training Policy
3. PREA Preventing Sexual Misconduct Against Offenders Training
4. NIC PREA for Community Confinement Facilities Training
5. Sample of Staff Training Records

Interviews:

1. Interview with Random Staff

Findings (By Provision):

115.231 (a): The Employee Training Policy, indicate that all staff are trained every two years on the PREA requirements/standards. The training consists of the agency's PREA Policies and Procedures, PREA Preventing Sexual Misconduct Against Offenders; the National Institute of Corrections (NIC) training for Medical and Mental Health Practitioners and the NIC's PREA training for Community Confinement Facilities. A review of the PREA training curriculums confirms that the facility trains all employees who may have contact with residents on the following: its zero tolerance policy, how to fulfill their responsibilities under the agency's sexual abuse and sexual harassment policies and procedures, the residents right to be free from sexual abuse and sexual harassment, the right of the resident to be free

from retaliation for reporting sexual abuse or sexual harassment, the dynamics of sexual abuse and sexual harassment in a confinement setting, the common reactions of sexual abuse and sexual harassment victims, how to detect and respond to signs of threatened and actual sexual abuse, how to avoid inappropriate relationship with residents, how to communicate effectively and professionally with lesbian, gay, bisexual, transgender and intersex residents and how to comply with relevant laws related to mandatory reporting. A review of twelve staff training records indicated that three of the twelve were hired in 2019 and received PREA training during the year. The nine other training records reviewed indicated that all had received PREA training, and eight of the nine had received it annually in 2018 and 2019. One record could not be located for 2019, however the staff member indicated he had received PREA training during 2019.

115.231 (b): The PAQ indicated that training is tailored to the gender of resident at the facility and that employees who are reassigned to facilities with opposite gender are given additional training. A review of the training curriculum confirms that training covers both male and female residents. A review of twelve staff training records indicated that three of the twelve were hired in 2019 and received PREA training during the year. The nine other training records reviewed indicated that all had received PREA training, and eight of the nine had received it annually in 2018 and 2019. One record could not be located for 2019, however the staff member indicated he had received PREA training during 2019.

115.231 (c): The PAQ indicated that 50 staff or 100% have been trained in PREA requirements and that they receive PREA training every two years. The PAQ also indicated that in between trainings staff are provided policies and current information on sexual abuse and sexual harassment. A review of twelve staff training records indicated that three of the twelve were hired in 2019 and received PREA training during the year. The nine other training records reviewed indicated that all had received PREA training, and eight of the nine had received it annually in 2018 and 2019. One record could not be located for 2019, however the staff member indicated he had received PREA training during 2019.

115.231 (d): The PAQ indicated that all staff are required to physically sign or electronically acknowledge that they received and understood the PREA training. A review of the training records indicate that all twelve staff signed a training roster indicating they completed the training and understood the training.

Based on a review of the PAQ, the Employee Training Policy, the PREA Preventing Sexual Misconduct Against Offenders Training Curriculum, the NIC PREA for Community Confinement Facilities Curriculum, a review of a sample of staff training records as well as interviews with random staff indicate that the facility meets this standard.

Standard 115.232: Volunteer and contractor training

115.232 (a)

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

115.232 (b)

- Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and

contractors shall be based on the services they provide and level of contact they have with residents)? ☒ Yes ☐ No

115.232 (c)

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

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Volunteer and Contractor Policy
3. PREA Volunteer Training Curriculum
4. PREA Acknowledgment Form
5. Sample of Contractor Training Records
6. Sample of Volunteer Training Records

Interviews:

1. Interview with Volunteers or Contractors who have Contact with Residents

Findings (By Provision):

115.232 (a): The PAQ indicated that volunteers and contractors who have contact with residents have been trained on their responsibilities under the facility's policies and procedures on sexual abuse and sexual harassment. The Volunteer and Contractor Policy describes the required training and indicates that the training is based on the type and level of services provided and the level of contact with offenders. Follow up with staff related to the PAQ indicated that 8 volunteers and 31 contractors had received PREA training, which is equivalent to 100%. A review of sample training documents for ten contractors and five volunteers indicated that 100% of those reviewed received PREA training. Additionally, the interview conducted with the non-security contract staff indicated that she had received PREA training, was aware of the zero-tolerance policy and knew to immediately report to security if she was informed of an allegation. All nine of the contracted security staff members indicated they were trained on PREA via staff training. There were no volunteers available for interviews during the on-site portion of the audit.

115.232 (b): The PAQ indicated that volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's policies and procedures on sexual abuse and sexual harassment. The Volunteer and Contractor Policy describes the required training and indicates that the training is based on the type and level of services provided and the level of contact with offenders. A review of the PREA Volunteer Training curriculum indicated that all contractor and volunteers are

trained on the agency's zero tolerance policy and how residents can report such incidents. The interview conducted with the non-security contract staff indicated that she had received PREA training, was aware of the zero-tolerance policy and knew to immediately report to security if she was informed of an allegation. All Gateway Foundation security staff are considered contractors but are required to go through the SMART employee training as well as Gateway Foundation training. There were no volunteers available for interviews during the on-site portion of the audit.

115.232 (c): The PAQ and a review of sample training documents for contractors and volunteers indicated that 100% of the volunteers reviewed had signed the PREA Acknowledgement Form. 100% of the contractors has signed the employee training completion. These forms document that they received and understood the training.

Based on a review of the PAQ, the Volunteer and Contractor Policy, the PREA Volunteer Training Curriculum, the PREA Acknowledgement Form, a review of a sample of contractor and volunteer training records as well as and interviews with contractors, this standard appears to be compliant.

Standard 115.233: Resident education

115.233 (a)

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

115.233 (b)

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

115.233 (c)

- Does the agency provide resident education in formats accessible to all residents, including those who: Are limited English proficient? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are deaf? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents, including those who: Are otherwise disabled? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents, including those who: Have limited reading skills? ☒ Yes ☐ No

115.233 (d)

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

115.233 (e)

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

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Resident Education
3. SMART Resident Orientation Information Form
4. Resident Orientation Handbook
5. Resident Training Records

Interviews:

1. Interview with Intake Staff
2. Interview with Random Residents

Site Review Observations:

1. Observations of Intake Area
2. Observations of PREA Signs in English and Spanish

Findings (By Provision):

115.233 (a): The Resident Education Policy outlines the requirement for residents to receive PREA education, specifically information on the agencies zero tolerance policy, how to report incidents or

suspicion of sexual abuse or sexual harassment, how to report incidents or suspicion of sexual abuse or sexual harassment, their right to be free from sexual abuse, sexual harassment and retaliation for reporting such incidents and policies for responding to such incidents. Residents receive orientation the day of their arrival. The PAQ indicated that 454 residents received information on the zero-tolerance policy and how to report at intake. The is equivalent to 100% of residents who received this information at intake. A review of documentation indicated the Resident Orientation Handbook as well as the SMART Resident Orientation Information Form included information on the zero-tolerance policy, the resident's rights under PREA and reporting methods. Both documents are provided to residents at intake. A review of a sample of resident files (20) indicated that 100% of those reviewed had been documented that they received PREA information within 24 hours of arrival at the facility. During the tour, the auditor observed the intake area and was provided an overview of the intake process. Residents were provided a handout/brochure, the orientation handbook and were also asked the risk screening questions during this time. The interview with intake staff indicated that the facility provides residents information related to the zero-tolerance policy and reporting mechanism via the PREA documents and that they go over it with the residents and highlight certain points. Random residents that were interviewed indicated that all but one of the residents remembered receiving PREA information. The majority indicated they received the information on the first day.

115.233 (b): The Resident Education Policy outlines that refresher information is provided to residents when they transfer to a different facility. The PAQ indicated that no residents transferred from another facility in the previous twelve months. All residents, regardless of how they arrive or where they arrive from are provided the resident education as outlined in policy. A review of a sample of resident PREA training records confirmed that all resident, whether transferred from a different facility or not, receive the required PREA information at intake.

115.233 (c): The Resident Education Policy describes the procedure to provide disabled residents an equal opportunity to benefit from all the aspects of the agency's efforts to prevent, detect and respond to sexual abuse and sexual harassment. Residents who are deaf or hard of hearing are provided information in American Sign Language (ASL) while resident who are blind or have an intellectual/cognitive disability would be read PREA information. The Resident Education Policy also outlines the procedure to ensure meaningful access to all the aspects of the agency's efforts to prevent, detect and respond to sexual abuse and sexual harassment to residents who are Limited English Proficient (LEP). Additionally, the policy indicates that a counselor is available for residents with limited reading or writing skills. Documents were reviewed and are available in Spanish and large size fonts if needed. The Interview with the Agency Head Designee indicated the facility would utilize a staff member to translate and auxiliary aids would be provided for any resident who needed assistance. The interview with the disabled resident indicated he receive PREA information in a format that he understood. During the tour, the PREA signage was observed to be in large text and in bright colors.

115.233 (d): Initial intake is completed when the resident signs the PREA Resident Orientation Information Form. A review of resident's files indicate that all 20 residents have been provided PREA education.

115.233 (e): The PAQ indicated that information is continuously available through education and informational materials. A review of documentation indicated that the facility had PREA information via the Resident Orientation Handbook and through PREA signage. During the tour, the auditor observed the PREA signage in each housing unit and in common areas.

Based on a review of the PAQ, the Resident Education Policy, the Resident Orientation Handbook, the PREA Resident Orientation Information Form, a sample of resident training records to include the PREA intake orientation form, observations made during the tour to include the availability of PREA information via signage and documents as well information obtained during interviews with intake staff and random residents indicate that this standard appears to be compliant.

Standard 115.234: Specialized training: Investigations

115.234 (a)

- In addition to the general training provided to all employees pursuant to §115.231, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators receive training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).)
  ☒ Yes ☐ No ☐ NA

115.234 (b)

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

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

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

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

115.234 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).)
  ☒ Yes ☐ No ☐ NA

115.234 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Specialized Training: Investigations Policy
3. PREA Resource Center Specialized Training: Investigating Sexual Abuse in a Confinement Setting
4. Investigator Training Records

Interviews:

1. Interview with Investigative Staff

Findings (By Provision):

115.234 (a): Facility staff are responsible for conducting administrative investigations only. The Specialized Training: Investigators Policy indicated that the PREA Coordinator and at least one additional staff member is required to complete the specialized training. The training was conducted by PREA Resource Center staff in Houston, Texas on April 15, 2019. The PAQ indicated that the facility has three staff investigators who have completed the required training. A review of training files for the staff indicate that Antisha Walley, Margie Kanada and Melissa Dager received the specialized training. The interview with the Facility Director indicated that Ms. Walley was the sole staff member now responsible for investigations. The interview with her indicated that she conducts administrative investigations while the Austin Police Department conducts criminal investigations. She indicated she received the specialized training that was conducted in Houston, TX.

115.234 (b): The PREA Resource Center Specialized Training: Investigating Sexual Abuse in a Confinement Setting training curriculum is utilized by the facility for their specialized training. The training curriculum includes the following; techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings and the criteria and evidence required to substantiate a case for administrative action or criminal prosecution. A review of investigator training records indicated that all three investigators received a certificate for completing the required training. The interview with the investigative staff member indicated the aforementioned topics were covered as well as requirements for reporting, objectivity, not asking leading questions, protecting the crime scene, ensuring an advocate is available and many more. She also indicated they did some role playing and hands on exercises during the training.

115.234 (c): The PAQ indicated that currently there are three investigators who complete PREA administrative investigations. A review of the training documents indicated that all investigators have received specialized training via the PREA Resource Center's training curriculum. The interview with the investigative staff member indicated that she received specialized training in Houston, TX and it was documented.

115.234 (d): No State entity or Department of Justice component is responsible for investigations. This section is not applicable.

Based on a review of the PAQ, the Specialized Training: Investigations Policy, the PREA Resource Center Specialized Training curriculum, a review of investigator training records as well as the interview with investigative staff, indicate that this standard appears to be compliant.

Standard 115.235: Specialized training: Medical and mental health care

115.235 (a)

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

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

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

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

115.235 (b)

- If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency does not employ medical staff or the medical staff employed by the agency do not conduct forensic exams.)
  ☐ Yes ☐ No ☒ NA

115.235 (c)

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

115.235 (d)

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

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

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Specialized Training: Medical and Mental Health Care Policy
3. NIC's Specialized Training: PREA Medical and Mental Health Care Standards Curriculum
4. Staff Training Records

Interviews:

1. Interview with Medical and Mental Health Staff

Findings (By Provision):

115.35 (a): The Specialized Training: Medical and Mental Health Care Policy requires that all medical and mental health care staff complete specialized training. While medical and mental health care services are very limited, the facility does have three medical staff available Monday through Friday, 8:00am to 4:00pm. Additionally, the facility employs mental health care staff. All medical and mental health care staff are required to complete the NIC's Specialized Training: PREA Medical and Mental Health Care Standards. This curriculum includes the following topics: how to detect and assess signs of sexual abuse and sexual harassment; how to preserve physical evidence of sexual abuse, how to respond effectively and professionally to victims of sexual abuse and sexual harassment and how and whom to report allegations or suspicion of sexual abuse and sexual harassment. The PAQ indicated that the facility has ten medical and mental health staff and that 100% of these staff received the specialized training. A review of medical and mental health training records for six staff indicated that all those reviewed received the specialized training. Interviews with medical and mental health staff confirmed that they had received the PREA specialized training.

115.35 (b): This provision does not apply. Forensic exams are not conducted on-site by any of the facility's medical staff. Residents are transported to a local hospital, where SAFE Alliance or nurses at

the hospital with specialized training completes the forensic medical examination. Interviews with medical and mental health care staff confirm that they do not perform forensic medical examinations.

115.35 (c): The PAQ indicated that documentation showing the completion of the training is maintained by the agency. A review of sample training documents for medical and mental health care staff confirm that staff who complete the specialized training receive a certificate from NIC. The certificate of completion is added to each staff members training file.

115.35 (d): All medical and mental health care staff, with the exception of one mental health staff member are SMART employees. The PAQ indicated that employees and contractors who have contact with residents have been trained on their responsibilities under the facility's policies and procedures on sexual abuse and sexual harassment. The PREA training provided to medical and mental health staff is the regular staff PREA training. A review of six medical and mental health staff training documents indicated that all had received the 2019 staff PREA training on November 19, 2019 and December 10, 2019. Additionally, the interviews conducted with medical and mental health staff confirmed that they had received PREA training.

Based on a review of the PAQ, the Specialized Training: Medical and Mental Health Care Policy, the NIC Specialized Training curriculum, a review of medical and mental health care staff training records as well as interviews with medical and mental health care staff indicate that this standard appears to be compliant.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.241: Screening for risk of victimization and abusiveness

115.241 (a)

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

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

115.241 (b)

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

115.241 (c)

- Are all PREA screening assessments conducted using an objective screening instrument?
  ☒ Yes ☐ No

115.241 (d)

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

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

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

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

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

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

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

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

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

115.241 (e)

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

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

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

115.241 (f)

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

115.241 (g)

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

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

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

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

115.241 (h)

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

115.241 (i)

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

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Screening for Risk of Victimization and Abusiveness Policy
3. Sexual Victimization and Abusiveness Risk Screening Form
4. Resident Assessment and Re-Assessment Records

Interviews:

1. Interview with Staff Responsible for Risk Screening
2. Interview with Random Residents
3. Interview with the PREA Coordinator
4.

Site Review Observations:

1. Observations of Risk Screening Area
2. Observations of Where Resident Files are Located

Findings (By Provision):

115.241 (a): The Screening for Risk of Victimization and Abusiveness Policy indicates that all residents will be assessed during the intake screening for their risk of being sexual abused by other residents or sexually abusive toward other residents. During the tour, the auditor observed the intake areas, however these areas are not where the risk screening occurs. The risk screenings are conducted in a private office setting. Interviews with random residents confirm that sixteen of the twenty residents remembered being asked the risk screening questions. The majority of the residents indicated the screening was completed the first day they arrived. A review of the twenty inmate files indicated all were asked the risk screening questions. The interview with the staff responsible for the risk screening indicated that residents are screened at intake on the first day.

115.241 (b): The Screening for Risk of Victimization and Abusiveness Policy indicates that all residents will be assessed during the intake screening for their risk of being sexual abused by other residents or sexually abusive toward other residents within 72 hours. The PAQ indicated that residents are screened within this timeframe and that 454 residents were received at the facility whose length of stay was for 72 hours or more. The PAQ indicated that 100% of those whose length of stay was for 72 hours or more received the risk screening within 72 hours. A review of a sample of resident files confirmed that all those reviewed had their risk screening completed within 72 hours.

115.241 (c): The PAQ indicated that the risk screening is conducted using an objective screening instrument. A review of the Sexual Victimization and Abusiveness Risk Screening Form indicated that residents answer yes or no questions. Many of these questions are later confirmed through review of the residents' history and file.

115.241 (d): A review of the Sexual Victimization and Abusiveness Risk Screening Form indicates that the intake screening considers the following criteria to assess residents for risk of sexual victimization: whether the resident has a mental, physical or developmental disability; the age of the resident; the physical build of the resident; whether the resident was previously incarcerated; whether the resident's criminal history is exclusively nonviolent; whether the resident has prior convictions for sex offenses against an adult or child; whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex or gender nonconforming; whether the resident has previously experienced sexual victimization and the residents own perception of vulnerability.

115.241 (e): A review of the Sexual Victimization and Abusiveness Risk Screening Form confirms that the intake screening considers the following; prior acts of sexual abuse, prior convictions for violent offenses and prior institutional violence or sexual abuse known to the facility. Interviews with intake staff confirm that these criteria are considered and utilized to determine if the resident is a potential predator and how to house accordingly.

115.241 (f): The Screening for Risk of Victimization and Abusiveness Policy indicates that residents would be reassessed for their risk of victimization or abusiveness within 30 days from their arrival at the facility. The PAQ indicated that the facility requires residents to be reassessed and that 133 residents were reassessed within 30 days. The PAQ indicated that 332 residents had a length of stay for 30 days or more. The numbers indicate that 40% of those residents whose length of stay was for 30 days or more received a reassessment. An interview with staff responsible for the risk screening indicated that residents are reassessed typically three weeks after arrival to ensure they have a week cushion to complete them in the required timeframe. Interviews with random residents indicated that the majority remember being asked the risk screening questions typically on the first. Only four of the twenty remember being reassessed and having the questions or similar questions asked again. The Facility Director and PC indicted that the reassessment component was implemented approximately six months ago and as such only 40% had been reassessed. A review of a sample of resident files indicated that all files reviewed with the exception of three that were not yet due for a reassessment, had been reassessed within the 30-day timeframe. While not all residents have been reassessed within the previous twelve months it is apparent via documentation that the reassessments are being completed systematically now and over the previous six months. While resident interviews indicated many did not remember the reassessment, it is noted that documentation shows they were completed and the reassessment is conducted in conjunction with other assessments with a mental health staff member.

115.241 (g): The Screening for Risk of Victimization and Abusiveness Policy indicates that residents would be reassessed for their risk of victimization or abusiveness when warranted due to referral, request, incident of sexual abuse or receipt of additional information that bears on their risk of sexual victimization or abusiveness. The PAQ indicated that this practice is occurring. An interview with the staff responsible for risk screening indicated this would occur and be part of the PREA trauma follow-up. The interview with the resident who reported sexual harassment indicated that she was reassessed after she reported the harassment. A review of the two resident files involved in the allegation (one victim and one alleged abuser) indicated the allegation was made on October 12, 2019, the victim was reassessed on October 22, 2019 and the alleged abuser was reassessed on October 29, 2019.

115.241 (h): The Screening for Risk of Victimization and Abusiveness Policy indicates that residents would not be disciplined for refusing to answer the following questions during the risk screening: whether or not the resident has a mental, physical or developmental disability; whether or not the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex or gender nonconforming; whether or not the resident previously experienced sexual victimization and the residents' own perception of vulnerability. The PAQ indicated that residents are not disciplined for refusing to answer. The interview with the staff responsible for risk screening indicated that residents are not disciplined for refusing to answer any of the questions in the risk screening. Interviews with random residents confirmed that they have never been disciplined for not answering any screening questions.

115.241 (i): The Screening for Risk of Victimization and Abusiveness Policy as well as the PAQ indicated that the facility has implemented appropriate controls on the dissemination of the screening information to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents. Interviews with the PREA Coordinator and staff responsible for the risk screening indicate that the information obtained during the risk screening is kept in a locked filing cabinet behind a locked door and that only the resident's counselor and leadership staff have access to the information.

Based on a review of the PAQ, the Screening for Risk of Victimization and Abusiveness Policy, the Sexual Victimization and Abusiveness Risk Screening Form, a review of resident files and information from interviews with the PREA Coordinator, staff responsible for conducting the risk screenings and random residents indicate that this standard appears to be compliant.

Standard 115.242: Use of screening information

115.242 (a)

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

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

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

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

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

115.242 (b)

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

115.242 (c)

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

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

115.242 (d)

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

115.242 (e)

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

115.242 (f)

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

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

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

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Use of Screening Information Policy
3. Sexual Victimization and Abusiveness Risk Screening Form

4. Transgender Housing Determination Documents
5. Resident Housing Assignments/Logs

Interviews:

1. Interview with Staff Responsible for Risk Screening
2. Interview with PREA Coordinator
3. Interview with Transgender/Intersex Residents
4. Interview with Gay, Lesbian and Bisexual Residents

Site Review Observations:

1. Location of Resident Records
2. Housing Assignments of LGBTI Residents
3. Shower Area in Housing Units

Findings (By Provision):

115.242 (a): The Use of Screening Information Policy indicates that the facility uses the information from the risk screening to inform housing, bed, work, education and program assignments with the goal of keeping separate residents at high risk of being sexual abused from those at high risk of being sexually abusive. Interviews with the PC and staff responsible for the risk screening indicated that residents who are determined to be at high risk of being sexual victimized would not be housed in a dorm with a resident that is at high risk of being sexual abusive. Additionally, the PC indicated they would use the screening to determine if the resident was suitable for the program. Additionally, interviews confirmed that residents at high risk of victimization would not be authorized work assignments or program/education assignments with residents at high risk of being sexually abusive. With the size of the facility and staffing pattern, staff are able to monitor resident to ensure they do not come into unsupervised contact with other residents. A review of resident files and of resident housing and work assignments confirmed that residents at high risk of victimization and residents at high risk of being sexually abusive were not housed together, did not work together and did not attend education/programs together.

115.242 (b): The PAQ indicated that the agency makes individualized determinations about how to ensure the safety of each resident. The interview with the staff responsible for the risk screening indicates that all residents who are at high risk of victimization or at high risk of being sexual abusive (as indicated via the risk screening) would be reviewed by leadership staff to determine the safest housing, work and program assignments.

115.242 (c): The Use of Screening Information Policy indicates that housing and program assignments for transgender and intersex residents are considered on a case by case basis to ensure the residents' health and safety, and whether the placement would present management or security problems. The interview with the PC indicated that these housing determinations are made on a case by case basis and that they typically communicate with the county jail where the resident was housed prior to the program to determine their housing there and any issues related to that housing. A review of documentation from the Facility Director related to the two identified transgender residents (one currently housed at the facility and one that was released just prior to the audit) indicated that leadership met and discussed each of these resident's housing and program assignments individually. The current transgender female resident was housed in "A" Building with the female residents. The interviews with transgender residents indicated that she was asked about her safety by staff and that while she was housed with the other transgender resident when the resident was at the facility it was not due to their gender identity. The interview indicated

that the resident had issues in numerous other female dorms and as such the final one she ended up in was with the other transgender resident.

115.242 (d): The Use of Screening Information Policy indicates that the residents own views with respect to his or her safety is given serious consideration. The interview with the PC and staff responsible for the risk screening indicated that transgender and intersex residents are asked about their safety during the assessments and this information is given serious consideration. The interviews with the transgender residents indicated she was asked about her view with respect to her safety and where she felt the safest being housed.

115.242 (e): The Use of Screening Information Policy indicates that transgender and intersex residents are given the opportunity to shower separately. During the tour it was confirmed that all residents are provided privacy while showering from one another via single showers and shower curtains. The interview with the PC and the staff responsible for risk screening confirmed that transgender and intersex residents can shower separately and can utilize the shower in a vacant dorm if needed. The transgender resident indicated in her interview that she was able to shower separately.

115.242 (f): The PAQ and a review of housing assignments for residents who identify as LGBTI indicated that these residents were assigned to various dorms throughout the facility. The interviews with the PC confirmed that LGBTI resident are not placed in one specific housing unit. The interviews with residents who identified as LGBTI indicated that all six did not feel they were placed in any specific dorm based on their sexual preference and/or gender identity.

Based on a review of the PAQ, the Use of Screening Information Policy, the Sexual Victimization and Abusiveness Risk Screening Form, a review of resident housing assignments, a review of transgender and intersex resident housing determinations and information from interviews with the PREA Coordinator, staff responsible for conducting risk screenings and LGBTI residents, indicates that this standard appears to be compliant.

REPORTING

Standard 115.251: Resident reporting

115.251 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? ☒ Yes ☐ No

115.251 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No

- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No

- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No

115.251 (c)

- Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties? ☒ Yes ☐ No

- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.251 (d)

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

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Resident Reporting Policy
3. Resident Handbook
4. PREA Posters

Interviews:

1. Interview with Random Staff
2. Interview with Random Residents
3. Interview with the PREA Coordinator

Site Review Observations:

1. Observation of PREA Reporting in all Housings Units

Findings (By Provision):

115.251 (a): The Resident Reporting Policy outlines that there are multiple ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse or sexual harassment and staff neglect or violation of responsibilities that may have contributed to such incidents. A review of additional documentation to include the resident handbook and PREA signage indicated that there are multiple ways for residents to report. These reporting mechanisms include: to any employee, contractor or volunteer, via grievance, by calling or writing the TDCJ PREA Ombudsman (936-437-5570) or by having any family member or friend report the allegation to the TDCJ PREA Ombudsman. During the tour, it was observed that information pertaining to how to report PREA allegations was indicated on the brightly colored PREA posters in all housing units and in common areas. Interviews with the sample of residents confirmed that they all were aware of the at least one method to report sexual abuse and sexual harassment. Most residents indicated that they would submit a grievance or call the phone number/hotline. Interviews with random staff confirm that they take all allegations seriously and that residents have multiple ways (those indicated above) to report sexual abuse and sexual harassment.

115.251 (b): The Resident Reporting Policy indicates that the agency has a way for residents to report abuse or harassment to a public or private entity that is not part of the agency, and that the entity can immediately forward the report back to the facility for investigation. A review of additional documentation to include the resident handbook and PREA signage confirm the agency provides information and phone number for the outside entity reporting method. The outside entity is the TDCJ PREA Ombudsman's Office. This office is operated by the Texas Department of Criminal Justice. During the tour, it was observed that information pertaining on how to report PREA allegations to the PREA Ombudsman's Office was posted in all housing units. Residents can call 936-437-5570 or can write to P.O. Box 99, Huntsville, TX 77342. The interview with the PC indicated that the residents could report to the PREA Ombudsman's Office, SAFE Alliance or Gateway Foundation hotline number and each entity would immediately relay the reported information back to the facility. Interviews with a sample of residents confirm that they are aware of the outside reporting mechanism (hotline) and that the information is posted in their housing area.

115.251 (c): The Resident Reporting Policy notes that staff are required to accept all reports made verbally, in writing, anonymously and from a third party and will promptly document any verbal reports. The PAQ indicated that staff accept all reports and that they immediately document any verbal allegations of sexual abuse or sexual harassment. A review of additional documentation to include the resident handbook and PREA signage indicated residents could report verbally, in writing, anonymously or through a third party. Interviews with a sample of residents confirm that they are aware of the methods available for reporting. Interviews with a sample of staff indicate they accept all allegations of sexual abuse and sexual harassment and they immediately report any allegation to their supervisor.

115.251 (d): The PAQ and Resident Reporting Policy describes that the agency provides a method for staff to privately report sexual abuse and sexual harassment of residents. Staff are able to submit a letter in a sealed envelope marked "Confidential" to the Facility Administrator, the PREA Coordinator, the Division Director or the Director. Interviews with a sample of staff indicate that they can privately report sexual abuse and sexual harassment of residents to any supervisor and could utilize the hotline number as well.

Based on a review of the PAQ, the Resident Reporting Policy, the resident handbook, PREA signage, observations from the facility tour related to PREA signage and posted information and interviews with the PC, random residents and random staff; this standard appears to be compliant.

Standard 115.252: Exhaustion of administrative remedies

115.252 (a)

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

115.252 (b)

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

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

115.252 (c)

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

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

115.252 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

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

- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension,

may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.252 (e)

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

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

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

115.252 (f)

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

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

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

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

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

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

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

115.252 (g)

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

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Exhaustion of Administrative Remedies Policy
3. Sample Grievances

Interviews:

1. Interview with Residents who Reported Sexual Abuse

Findings (By Provision):

115.252 (a): The Exhaustion of Administrative Remedies is the policy related to resident grievances. The PAQ indicated that the agency is not exempt from this standard.

115.52 (b): The Exhaustion of Administrative Remedies outlines the grievance process for allegations of sexual abuse and sexual harassment. Specially, that the agency does not impose a time limit on when an resident may submit a grievance regarding an allegation of sexual abuse. It also discusses that the agency does not require an resident to use the informal grievance process, or attempt to resolve with staff, an alleged incident of sexual abuse. A review of the resident handbook indicated that page 16 and 17 discuss the grievance procedures for the facility. The PAQ indicated that three grievances were submitted alleging sexual abuse. After a discussion with the facility it was determined that the PAQ was incorrect and that there were three client reports of sexual abuse in writing, not via grievances. A review of a sample of ten grievances confirmed there were no sexual abuse or sexual harassment grievances filed in the previous twelve months.

115.252 (c): The Exhaustion of Administrative Remedies outlines the grievance process for allegations of sexual abuse and sexual harassment. Specially, that the resident may submit a grievance without submitting it to the staff member who is the subject of the complaint and grievances will not be referred to staff members who are the subject of the complaint. A review of the resident handbook indicated that page 16 and 17 discuss the grievance procedures for the facility. The PAQ indicated that three grievances were submitted alleging sexual abuse. After a discussion with the facility it was determined

that the PAQ was incorrect and that there were three client reports of sexual abuse in writing, not via grievances. A review of a sample of ten grievances confirmed there were no sexual abuse or sexual harassment grievances filed in the previous twelve months.

115.252 (d): The Exhaustion of Administrative Remedies outlines the grievance process for allegations of sexual abuse and sexual harassment. Specially, that the agency would issue a final decision on grievances related to sexual abuse within 90 days of the initial filing. The 90 days does not include the time used by the resident to prepare any administrative appeal. The agency may claim an extension up to 70 days if the normal time period for response is insufficient to make an appropriate decision. The resident must be notified in writing of the extension and provide a date by which the decision will be made. The policy also indicates that if the resident does not receive a response within the allotted timeframe, the resident will consider the absence of a response to be a denial. The PAQ indicated that three grievances were submitted alleging sexual abuse. After a discussion with the facility it was determined that the PAQ was incorrect and that there were three client reports of sexual abuse in writing, not via grievances. A review of a sample of ten grievances confirmed there were no sexual abuse or sexual harassment grievances filed in the previous twelve months.

115.252 (e): The Exhaustion of Administrative Remedies outlines the grievance process for third party allegations of sexual abuse and sexual harassment. Specially, that third parties are permitted to assist residents in filing request for administrative remedies for sexual abuse and are permitted to file such request on behalf of the resident. In addition, it states that if a third-party files a report on behalf of an resident that the agency may require the alleged victim to agree with the request prior to filing and if the resident declines will document the resident's decision. The PAQ indicated that there have been zero third party grievances in the previous twelve months.

115.252 (f): The Exhaustion of Administrative Remedies outlines the grievance process for allegations of sexual abuse and sexual harassment. Specially, that the agency provides residents the opportunity to file an emergency grievance alleging substantial risk of imminent sexual abuse and the grievance will be addressed immediately. The policy indicates that that an initial response will be provided within 48 hours and that a final decision will be provided within five calendar days. The final decision will document the agency's determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance. The PAQ indicated that there have been zero emergency grievances alleging substantial risk of imminent sexual abuse filed in the previous twelve months.

115.252 (g): The Exhaustion of Administrative Remedies indicates that the resident may be disciplined for filing a grievance in bad faith. The PAQ indicated that no residents have been disciplined for filing a grievance in bad faith in the previous twelve months.

Based on a review of the PAQ, the Exhaustion of Administrative Remedies policy, a review of a sample of grievances and information obtained from interviews with residents who reported sexual abuse, this standard appears to be compliant.

Standard 115.253: Resident access to outside confidential support services

115.253 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers,

including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? ☒ Yes ☐ No

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

115.253 (b)

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

115.253 (c)

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

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

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Resident Access to Outside Confidential Support Services Policy
3. Memorandum of Understanding (MOU) with SAFE Alliance
4. SMART Resident Orientation Information

Interviews:

1. Interview with Random Residents
2. Interview with Residents who Reported Sexual Abuse (Sexual Harassment)

Site Review Observations:

1. Observations of Victim Advocacy Information

Findings (By Provision):

115.53 (a): The Resident Access to Outside Confidential Support Services Policy indicates that the agency provides access to outside victim advocates for emotional support related to sexual abuse by

giving residents mailing addresses and telephone numbers to victim advocates or rape crisis organizations and enables reasonable communication in as confidential manner as possible. The PAQ indicated that residents were provided mailing addresses and phone numbers and that they enabled reasonable communication with these services in as confidential a manner as possible. A review of the MOU with SAFE Alliance indicates that this organization provides emotional support services to residents of the facility. The SMART Resident Orientation Information form, which is provided at intake, includes the mailing address (PO Box 19454, Austin, TX 78760) and the phone number (512-267-7233) for resident support services. Interviews with random residents and residents who reported sexual abuse indicated that the majority were familiar with the process of having emotional support services, but they weren't 100% certain when they would access these services. Most residents indicated they believed the information was posted on the PREA poster. The resident who reported sexual harassment advised that she was not provided any information related to victim advocacy services specifically, but that the information was posted.

115.53 (b): The Resident Access to Outside Confidential Support Services Policy confirms that prior to giving residents access to outside support services that they are informed of the extent which communication will be monitored as well as any mandatory reporting rules and limits to confidentially. A review of the PAQ as well as the SMART Resident Orientation Information form indicated that residents were informed that services through SAFE Alliance are confidential. Interviews with random residents and residents who reported sexual abuse indicated that the majority were familiar with the process of having emotional support services, but they weren't 100% certain when they would access these services. Most residents indicated they believed the information was posted on the PREA poster.

115.53 (c): A review of the MOU with SAFE Alliance indicates that this organization provides emotional support services to residents of the facility. The MOU was executed on October 30, 2017 and does not have an expiration date.

Based on a review of the PAQ, the Resident Access to Outside Confidential Support Services Policy, the SMART Resident Orientation Information, the MOU with SAFE Alliance, observations from the facility tour related to PREA signage and posted information and interviews with random residents and resident who reported sexual abuse, this standard appears to be compliant.

Standard 115.254: Third-party reporting

115.254 (a)

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

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

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Third Party Reporting Policy
3. Facility Brochure

Findings (By Provision):

115.54 (a): The PAQ indicated that the agency has a method to receive third-party reports of sexual abuse and sexual harassment and publicly distributes that information on how to report sexual abuse and sexual harassment on behalf of an resident. A review of the Third Party Reporting Policy as well as the facility's brochure confirms that third parties can report on behalf of a resident. Third parties can report via the TDCJ PREA Ombudsman (936-437-5570), the Gateway Foundation Third Party Reporting Line (1-800-457-2598) or online report (http://gatewaycorrections.org/prea/reporting/) as well as by calling the Facility Administrator (512-854-315).

Based on a review of the PAQ, the Third-Party Reporting Policy and the Facility Brochure, this standard appears to be compliant.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.261: Staff and agency reporting duties

115.261 (a)

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? ☒ Yes ☐ No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? ☒ Yes ☐ No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? ☒ Yes ☐ No

115.261 (b)

- Apart from reporting to designated supervisors or officials, do staff always refrain from revealing any information related to a sexual abuse report to anyone other than to the extent necessary,

as specified in agency policy, to make treatment, investigation, and other security and management decisions? ☒ Yes ☐ No

115.261 (c)

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

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

115.261 (d)

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

115.261 (e)

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

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Staff and Agency Reporting Duties Policy

Interviews:

1. Interview with Random Staff
2. Interview with Medical and Mental Health Staff
3. Interview with the Facility Director
4. Interview with the PREA Coordinator

Findings (By Provision):

115.261 (a): The Staff and Agency Reporting Duties Policy outline the staff and agency reporting duties. Specifically, it requires all staff to promptly report any knowledge, suspicion or information regarding an incident of sexual abuse or sexual harassment, retaliation against any resident or staff that reported such incidents and any staff neglect or violation of responsibility that may have contributed to an incident. The PAQ along with interviews with random staff confirm that they take all allegations seriously and that they

know they are required and would report any knowledge, suspicion or information regarding an incident of sexual abuse and sexual harassment. Interviews also confirmed they would report retaliation or any staff neglect related to these incident types.

115.261 (b): The Staff and Agency Reporting Duties Policy describes that staff will not reveal any information related to an incident of sexual abuse other than as necessary for treatment, investigation and other security decisions. The PAQ along with interviews with random staff confirm that they would immediately report the information to their supervisor. Staff indicated this would be the extent of distributing information unless they were required to write a statement.

115.261 (c): The Staff and Agency Reporting Duties Policy indicates that medical and mental health staff are required to report sexual abuse as described in section (a) and that they are required to inform residents of their duty to report and limits to confidentiality at the initiation of services. The PAQ along with interviews with medical and mental health care staff confirm that they would immediately report any allegation of sexual abuse that occurred within a confinement setting. Medical and mental health care staff indicated they are required to inform residents of the limits of confidentiality.

115.261 (d): The Staff and Agency Reporting Duties Policy indicates that any alleged victims under the age of 18 or considered to be a vulnerable adult would require the agency to report the allegation to the designated State or local service under applicable mandatory reporting laws. The PAQ along with interviews with the PREA Coordinator and the Facility Director indicated that they had not had any of these reports but if they did, the Department of Family and Protective Services would be notified.

115.261 (e): The Staff and Agency Reporting Duties Policy indicates that all allegations of sexual abuse and sexual harassment, including third party and anonymous reports would be promptly reported. The PAQ along with the interview with the Facility Director confirmed that this is the practice. A review of investigative reports indicate that all allegations are reported to the Facility Director who reports to the PREA Coordinator and Facility Investigator and, if applicable, the Austin Police Department.

Based on a review of the PAQ, the Staff and Agency Reporting Duties Policy and interviews with medical, mental health, the PREA Coordinator and the Facility Director confirm that this standard appears to be compliant.

Standard 115.262: Agency protection duties

115.262 (a)

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

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. The Staff and Agency Reporting Duties Policy

Interviews:

1. Interview with the Agency Head Designee
2. Interview with the Facility Director
3. Interview with Random Staff

Findings (By Provision):

115.62 (a): The Staff and Agency Reporting Duties Policy indicates that when the agency learns that an resident is subject to substantial risk of imminent sexual abuse, it takes immediate action to protect the resident. The PAQ noted that there were no residents who were determined to be at risk of imminent sexual abuse. Interviews indicated that if an resident is having issues with other residents, that the facility would make appropriate housing changes, if necessary. The interviews with the Agency Head Designee and Facility Director indicated that any resident at risk would immediately be taken to a safe location. At that time, they would review to determine if housing changes were required or if one of the residents needed to be removed from the program. Interviews with random staff indicated that they would immediately remove the resident from the situation.

Based on a review of the PAQ, the Staff and Agency Reporting Duties Policy and interviews with the Agency Head Designee, Facility Director and random staff indicate that this standard appears to be compliant.

Standard 115.263: Reporting to other confinement facilities

115.263 (a)

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

115.263 (b)

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

115.263 (c)

- Does the agency document that it has provided such notification? ☒ Yes ☐ No

115.263 (d)

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

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Reporting to Other Confinement Facility Policy

Interviews:

1. Interview with the Agency Head
2. Interview with the Facility Director

Findings (By Provision):

115.263 (a). The Reporting to Other Confinement Facilities Policy describes the requirements for reporting to other confinement facilities. Specifically, it requires that upon receiving an allegation that a resident was sexually abused while confined at another facility, the Facility Administrator will notify the head of the facility or the appropriate office of the agency. The PAQ indicated that during the previous twelve months, the facility has not had any residents report that they were abused while confined at another facility.

115.263 (b): The Reporting to Other Confinement Facilities Policy describes the requirements for reporting to other confinement facilities. Specifically, it requires that upon receiving an allegation that a resident was sexually abused while confined at another facility, the Facility Administrator will notify the head of the facility where the alleged abuse occurred within 72 hours. The PAQ indicated that during the previous twelve months, the facility has not had any residents report that they were abused while confined at another facility.

115.263 (c): The Reporting to Other Confinement Facilities Policy describes the requirements for reporting to other confinement facilities. Specifically, it requires that upon receiving an allegation that a resident was sexually abused while confined at another facility, the Facility Administrator will notify the head of the facility where the alleged abuse occurred and documentation will be retained that such notification occurred. The PAQ indicated that during the previous twelve months, the facility has not had any residents report that they were abused while confined at another facility.

115.263 (d): The Reporting to Other Confinement Facilities Policy indicates that if the facility receives information from another agency head that a resident alleges they were sexually abused while housed at the facility, the allegation will be reported to the Facility Administrator who will ensure it is investigated. The PAQ indicated that during the previous twelve months, the facility has not had any residents report that they were abused while confined at another facility. Interviews with the Agency Head Designee and the Facility Director indicated that the allegation would be immediately documented and investigated.

Based on a review of the PAQ, the Reporting to Other Confinement Facilities Policy and interviews with the Agency Head Designee and Facility Director, this standard appears to be compliant.

Standard 115.264: Staff first responder duties

115.264 (a)

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

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

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

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

115.264 (b)

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

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Staff and First Responder Duties Policy
3. Investigative Reports

Interviews:

1. Interview with Security Staff and Non-Security Staff First Responders

Findings (By Provision):

115.264 (a). The Staff and First Responder Duties Policy describes staff first responder duties. Specifically, it requires that upon learning that an resident was sexually abused, the first security staff member will: separate the alleged victim and the alleged perpetrator; preserve and protect any crime scene until evidence can be collected and if the abuse occurred within a time period that still allows for the collection of physical evidence request that the alleged victim and ensure that the alleged perpetrator not take any action to destroy physical evidence, including washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating. The PAQ indicated that during the previous twelve months, there have been three allegations of sexual abuse. After review, one did not rise to the level of PREA. Of the two allegations (one allegation was investigated administratively and criminally and as such there are three total sexual abuse investigations documented in the table on page 10), both required the victim and alleged abuser to be separated and one allowed for the collection of physical evidence (a letter). None of the allegations allowed for collection of physical evidence from the victim and/or the alleged abuser. A review of the two sexual abuse investigative reports confirmed that staff separated the victim and alleged perpetrator. The allegations did not involve penetration and as such no physical evidence was able to be collected, nor was there any physical evidence that could be destroyed. All random staff interviewed were well versed first responder duties. Staff indicated they would separate the alleged victim and alleged perpetrator, would secure the crime scene and would instruct residents not to destroy any physical evidence. The interview with resident who reported sexual harassment indicate that staff immediately separated her from the alleged perpetrator.

115.264 (b): The Staff and First Responder Duties Policy describe staff first responder duties. Specifically, it requires that non-security staff first responders advise the victim and alleged perpetrator not to take any action to destroy physical evidence, if it occurred within a time period that still allows for the collection of physical evidence. Staff would tell the resident not to wash, brush their teeth, change their clothes, urinate, defecate, smoke, drink or eat. The PAQ indicated that during the previous twelve months, there have been three allegations of sexual abuse. After review, one did not rise to the level of PREA. None of the allegations involved penetration or physical contact that would allow for collection of physical evidence. As such, none required the instruction by staff to residents not to destroy any evidence on their person. Interviews with first responders (security and non-security) confirm that they are aware of their first responder duties. Staff were very well versed on first responder duties.

Based on a review of the PAQ, the Staff and First Responder Duties Policy, sexual abuse incident reports, sexual abuse investigative reports and interviews with first responders, this standard appears to be compliant.

Standard 115.265: Coordinated response

115.265 (a)

- Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Coordinated Response Policy

Interviews:

1. Interview with the Facility Director

Findings (By Provision):

115.65 (a): The PAQ indicated that the facility has a written plan that coordinates actions taken in response to incidents of sexual abuse among staff first responders, medical and mental health, investigators and facility leaders. The Coordinated Response Policy outlines the coordinated response from security, medical, mental health, investigators and leadership. A review of the coordinated response shows that all areas are accounted for in the plan. Each section includes the actions that each person and/or department is responsible for and includes information on how all areas work together to respond to allegations. The Facility Director confirmed that the facility has a plan and that it includes all the required components.

Based on a review of the PAQ, the Coordinated Response Policy and the interview with the Facility Director, this standard appears to be compliant.

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

115.266 (a)

- Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted? ☒ Yes ☐ No

115.266 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Preservation of Ability to Protect Residents from Contact with Abusers Policy

Interviews:

1. Interview with the Agency Head Designee

Findings (By Provision):

115.66 (a): The PAQ indicated that the agency does not have any collective bargaining agreement. The Preservation of Ability to Protect Residents from Contact with Abusers Policy indicates that the agency nor any other governmental agency can limit the agency's ability to remove alleged staff sexual abusers from contact with any resident. The interview with the Agency Head Designee confirmed that the agency has no collective bargaining or any entity that would be able to have collective bargaining on the agency's behalf.

115.66 (b): The PAQ indicated that the agency does not have any collective bargaining agreement. The Preservation of Ability to Protect Residents from Contact with Abusers Policy indicates that the agency nor any other governmental agency can limit the agency's ability to remove alleged staff sexual abusers from contact with any resident. The interview with the Agency Head Designee confirmed that the agency has no collective bargaining or any entity that would be able to have collective bargaining on the agency's behalf.

Based on a review of the PAQ, the Preservation of Ability to Protect Residents from Contact with Abusers Policy and the interview with the Agency Head Designee, this standard appears to be compliant.

Standard 115.267: Agency protection against retaliation

115.267 (a)

- Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff? ☒ Yes ☐ No

- Has the agency designated which staff members or departments are charged with monitoring retaliation? ☒ Yes ☐ No

115.267 (b)

- Does the agency employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with

victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations? ☒ Yes ☐ No

115.267 (c)

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor any resident disciplinary reports? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident housing changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident program changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor negative performance reviews of staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor reassignments of staff? ☒ Yes ☐ No

- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? ☒ Yes ☐ No

115.267 (d)

- In the case of residents, does such monitoring also include periodic status checks? ☒ Yes ☐ No

115.267 (e)

- If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation?
  ☒ Yes ☐ No

115.267 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Agency Protection Against Retaliation Policy
3. Monitoring for Retaliation Documents

Interviews:

1. Interview with the Agency Head Designee
2. Interview with the Facility Director
3. Interview with Designated Staff Member Charged with Monitoring Retaliation
4. Interview with Residents who Reported Sexual Abuse (Sexual Harassment)

Findings (By Provision):

115.267 (a): The Agency Protection Against Retaliation outlines the facility's method for protection against retaliation. It addresses that the facility will protect all residents and staff who report sexual abuse and sexual harassment from retaliation by other residents and staff and has designated staff responsible for monitoring. The PAQ indicated that the facility has a policy and that Facility Director and the management team would be responsible for monitoring for retaliation. The Facility Director indicated that all incidents within 30 days are reviewed during the 30-day review with the management team.

115.267 (b): The Agency Protection Against Retaliation outlines the facility's protection against retaliation. It addresses the multiple measures that the facility will take to protect residents and staff. These measures include; housing changes or transfers, removal of the alleged staff abuser from contact with the victim and emotional support services for residents and staff. A review of investigative reports indicated that no resident victims or alleged perpetrators (staff or resident) reported retaliation. Interviews with the Agency Head Designee, Facility Director and staff responsible for monitoring retaliation all indicated that protective measures would be taken if an resident or staff member expressed fear of retaliation, including separation, conducting mental health assessments and providing contact with SAFE Alliance. Interviews indicated that the facility would make any necessary housing changes and/or work changes and would follow up with any administrative action on staff such as shift change, removal or discipline. The interview with the resident who reported sexual harassment indicated that she had not

been asked any information related to retaliation, however the allegation was sexual harassment and as such the standard does not require monitoring on sexual harassment allegations. The resident did advise that she was moved to a different dorm and staff asked her if she felt safe and followed up with her.

115.267 (c): The Agency Protection Against Retaliation outlines the facility's protection against retaliation. It addresses that the facility will monitor the resident for at least 90 days following a report of sexual abuse and will monitor the conduct and treatment of the resident or staff to see if there are any changes that may suggest possible retaliation and will act promptly to remedy any retaliation. The policy requires that the process include; monitoring any resident disciplinary reports, housing or program changes or any negative performance reviews or reassignments of staff. The policy indicates that monitoring can extend beyond 90 days if the initial monitoring indicates a need to continue. The PAQ indicated that the facility monitors for retaliation and that it does so for at least 90 days. The PAQ indicated that there had been no instances of retaliation in the previous twelve months. A review of investigative reports indicated that no resident victims or alleged perpetrators (staff or resident) reported retaliation. The interview with the monitoring staff indicated that the facility would review the resident for at least 90 days and would check the resident's disciplinary reports, housing change and program changes. These reviews would be conducted monthly and all incidents within the 30 days would be reviewed by the Facility Director and the management team. Monitoring staff also indicated they have not had to monitor staff in the previous twelve months but if they did, they would check performance reviews and post assignment changes.

115.267 (d): The Agency Protection Against Retaliation outlines the facility's protection against retaliation. It addresses that the facility will monitor the resident for at least 90 days following a report of sexual abuse and will conduct periodic status checks. The PAQ indicated that there had been no instances of retaliation in the previous twelve months. A review of investigative reports indicated that no resident victims or alleged perpetrators (staff or resident) reported retaliation. The interview with the monitoring staff indicated that the facility would review the resident for at least 90 days and would include checks. The checks would be conducted by the lead mental health professional and information would be reported back to the management team to review. These reviews would be conducted monthly and all incidents within the 30 days would be reviewed by the Facility Director and the management team.

115.267 (e): The Agency Protection Against Retaliation outlines the facility's protection against retaliation. It addresses that the facility will take appropriate measures to protect any individual who cooperates with an investigation or expresses fear of retaliation. A review of investigative reports indicated that a witness in a reported sexual abuse allegation reported she was retaliated against for cooperating with the investigation. A review of documentation indicated that the resident was moved from the dorm with the other residents she indicated she was being retaliated against by. The resident did not report any future retaliation and the issues seemed to be resolved with the housing change. Interviews with the Agency Head Designee and Facility Director indicated that they would employ the same protective measures as state previously related to staff and residents to include, housing changes, administrative action, removal of staff and/or disciplinary action.

115.267 (f): Auditor not required to audit this provision.

Based on a review of the PAQ, the Agency Protection Against Retaliation policy, monitoring documents for the witness to feared and reported retaliation and interviews with the Agency Head Designee, Facility Director and staff charged with monitoring for retaliation, this standard appears to be compliant.

INVESTIGATIONS

Standard 115.271: Criminal and administrative agency investigations

115.271 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).) ☒ Yes ☐ No ☐ NA

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).) ☒ Yes ☐ No ☐ NA

115.271 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations as required by 115.234? ☒ Yes ☐ No

115.271 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? ☒ Yes ☐ No

- Do investigators interview alleged victims, suspected perpetrators, and witnesses? ☒ Yes ☐ No

- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? ☒ Yes ☐ No

115.271 (d)

- When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution? ☒ Yes ☐ No

115.271 (e)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff? ☒ Yes ☐ No

- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? ☒ Yes ☐ No

115.271 (f)

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? ☒ Yes ☐ No

- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? ☒ Yes ☐ No

115.271 (g)

- Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible? ☒ Yes ☐ No

115.271 (h)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution? ☒ Yes ☐ No

115.271 (i)

- Does the agency retain all written reports referenced in 115.271(f) and (g) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years? ☒ Yes ☐ No

115.271 (j)

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation? ☒ Yes ☐ No

115.271 (k)

- Auditor is not required to audit this provision.

115.271 (l)

- When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.221(a).) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Criminal and Administrative Agency Investigations Policy
3. MOU with Austin Police Department
4. Investigator Training Records
5. Investigative Reports

Interviews:

1. Interview with Investigative Staff
2. Interview with Residents who Reported Sexual Abuse (Sexual Harassment)
3. Interview with the Facility Director
4. Interview with the PREA Coordinator

Findings (By Provision):

115.271 (a): The Criminal and Administrative Agency Investigation Policy describes how allegations of sexual abuse and sexual harassment will be conducted promptly, thoroughly and objectively. There were sixteen allegations of sexual abuse and/or sexual harassment at the facility for the previous twelve months. After a review of the allegations, the auditor determined that eight allegations were not PREA allegations as they did not rise to the level of PREA; four were not repeated, two were related to official duties and two did not meet the PREA definition. One allegation had both an administrative and criminal investigation. Although they did not rise to the level of PREA, all sixteen allegations were investigated promptly, thoroughly and objectively. The interview with the facility investigator confirmed that all investigations are completed promptly, thoroughly and objectively.

115.271 (b): The PAQ indicated that currently there are three investigators who complete PREA investigations at the facility, all criminal investigations are completed by the Austin Police Department. A review of training documents confirmed that all facility investigators have received specialized training. The MOU with the Austin Police Department indicates the Sex Crimes Unit handle all sexual abuse allegations at the facility. The Police Department staff have extensive investigative training and experience. The interview with the investigative staff confirmed that she received specialized training via the PREA Resource Center Specialized Investigator Training in Houston, TX.

115.271 (c): The Criminal and Administrative Agency Investigation Policy describes the investigation process. Specifically, it requires investigators to gather and preserve evidence, including physical, DNA, electronic monitoring data, interviews of victims, subjects and witnesses and to review prior complaints involving the alleged perpetrator. Criminal investigations are completed by the Austin Police Department who are experienced law enforcement personnel. There were sixteen allegations of sexual abuse and/or sexual harassment at the facility for the previous twelve months. After a review of the allegations, the auditor determined that eight allegations were not PREA allegations as they did not rise to the level of PREA; four were not repeated, two were related to official duties and two did not meet the PREA definition. The review also confirmed that applicable evidence was collected in all cases. While no allegations were made that required the collection of physical evidence to include DNA, all relevant evidence, to include video monitoring technology and resident statements were collected. The interview with investigative staff confirmed that if penetration occurred that the Austin Police Department would be contacted and would respond immediately. The resident would be transported to the hospital for a forensic examination and the crime scene would be secured until evidence collection could be initiated.

For investigations occurring by her (the facility investigator) there would be camera reviews, a collection of statements of all involved residents and collection of any other applicable evidence.

115.271 (d): The Criminal and Administrative Agency Investigation Policy describes the investigation process. Criminal investigations are completed by the Austin Police Department who are experienced law enforcement personnel. The Police Officer/Detective would follow their policy and procedure related to compelled interviews. The interview with the facility investigator indicated that the Austin Police Department would deal with compelled interviews.

115.271 (e): The Criminal and Administrative Agency Investigation Policy describes the investigation process. Specifically, it states that the credibility of the alleged victim, perpetrator and/or witness will be assessed on an individual basis and will not be determined based on the individual's status as an resident or staff member. Additionally, it indicates that residents would not be required to submit to a polygraph examination or any other truth-telling device as a condition for proceeding with the investigation. The interview with the facility investigator confirmed that the agency does not utilize polygraph tests or any other truth-telling devices on residents who allege sexual abuse. She also indicated she would treat all involved as credible until proven otherwise. The resident who reported a PREA allegation confirmed that she was not required to take a polygraph test.

115.271 (f): The Criminal and Administrative Agency Investigation Policy describes the investigation process. Specifically, it states that all administrative investigation will include an effort to determine whether staff actions or failure to act contributed to the abuse and shall be documented in a written report that includes a description of the physical and testimonial evidence, the reasoning behind credibility assessments and investigative facts and findings. Fifteen administrative investigations were conducted in the previous twelve months. After a review of the allegations, the auditor determined that eight allegations were not PREA allegations as they did not rise to the level of PREA; four were not repeated, two were related to official duties and two did not meet the PREA definition. A review of these investigative reports indicted all had a written report that included a description of physical and testimonial evidence, investigative and facts and findings. Additionally, none indicated that staff actions contributed to any alleged abuse. The interviews with the facility investigator confirmed that administrative investigations would be documented in written reports and include information related to the allegation, victim and suspect interviews, witness interviews, video evidence, if applicable, description of any physical evidence, if applicable, and investigative facts and findings.

115.271 (g): The Austin Police Department is responsible for conducting criminal investigations. The law enforcement agency has policies and procedures in place related to report writing and what is required to be included. The Criminal and Administrative Agency Investigation Policy describes that all criminal investigations are required to be in a written report with a description of physical, testimonial and documentary evidence. There has been one criminal investigation completed related to sexual abuse within the previous twelve months. A review of the investigative report indicated that the criminal investigation was documented in written reports and included information related to the allegation, victim and suspect interviews, witness interviews, video evidence, description of any physical evidence and investigative facts and findings. The interview with the facility Investigator confirmed that criminal investigations are completed by the Austin Police Department in a written document and that physical, testimonial and documentary evidence is included.

115.271 (h): The PAQ indicated that substantiated allegations of conduct that appear to be criminal will be referred for prosecution by the Austin Police Department. The PAQ indicated that there have not been any allegations referred for prosecution since the last PREA audit. The interview with the facility

investigator indicated that the Austin Police Department would be responsible for referring cases for prosecution.

115.271 (i): The Criminal and Administrative Agency Investigation Policy describes the investigation process. Specifically, it indicates that all written reports will be retained as long as the alleged abusers is incarcerated or employed by the agency, plus five years. A review of a sample of historical reports indicated that these records are retained as required by the standard.

115.271 (j): The Criminal and Administrative Agency Investigation Policy describes the investigation process. Specifically, it indicates that the departure of the alleged victim or alleged abuser from employment or custody does not provide a basis for terminating an investigation. Three sexual abuse investigations were completed within the previous twelve months. The interview with the facility investigator confirmed that all investigations are completed no matter if staff leave/resign or if residents depart the facility or agency's custody.

115.271 (k): No State entity or Department of Justice component is responsible for conducting investigations for the facility.

115.271 (l): The Austin Police Department is responsible for conducting investigations at the facility. The MOU with the Police Department as well as the Criminal and Administrative Agency Investigation Policy indicate that the facility is required to cooperate and remain informed throughout the investigation. Interviews with the Facility Director, PREA Coordinator and facility investigative indicated that the Police Department provides a copy of the investigative report to the facility and that the facility investigator can inquire during the investigation about the progress.

Based on a review of the PAQ, the Criminal and Administrative Agency Investigation Policy, the MOU with the Austin Police Department, investigative reports, training records and information from interviews with the Agency Head Designee, Facility Director, PREA Coordinator, investigative staff and residents who reported sexual harassment, this standard appears to be compliant.

Standard 115.272: Evidentiary standard for administrative investigations

115.272 (a)

- Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Criminal and Administrative Agency Investigations Policy

Interviews:

1. Interview with Investigative Staff

Findings (By Provision):

115.272 (a): The Criminal and Administrative Agency Investigation Policy describes the investigative process. Specifically, part Q indicates that the agency does not impose no higher standard than a preponderance of evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. A review of the records indicated that eight sexual abuse or sexual harassment administrative investigations were completed within the previous twelve months. Seven allegations were determined to be unfounded or unsubstantiated, while on was substantiated. The interview with the facility investigator confirmed that all investigations only require a preponderance of evidence to make a substantiated finding.

Based on a review of the PAQ, the Criminal and Administrative Agency Investigation Policy and information from the interviews with investigative staff it is determined that this standard appears to be compliant.

Standard 115.273: Reporting to residents

115.273 (a)

- Following an investigation into a resident's allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded? ☐ Yes ☒ No

115.273 (b)

- If the agency did not conduct the investigation into a resident's allegation of sexual abuse in the agency's facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) ☒ Yes ☐ No ☐ NA

115.273 (c)

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.273 (d)

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.273 (e)

- Does the agency document all such notifications or attempted notifications? ☐ Yes ☒ No

115.273 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Reporting to Residents Policy
3. Investigative Reports

Interviews:

1. Interview with the Facility Director
2. Interview with Investigative Staff
3. Interview with Residents who Reported Sexual Abuse (Sexual Harassment)

Findings (By Provision):

115.273 (a): The Reporting to Residents describes the process for reporting investigative information to residents. Specifically, it states that following an investigation into an resident's sexual abuse allegation, the facility will inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated or unfounded. The PAQ indicated that there were four sexual abuse investigation completed within the previous twelve months. A review of the four sexual abuse investigations (one criminal and one administrative for the same case and one that did not rise to the level of PREA) indicated that resident victims were not documented to have been informed of the outcome of the investigations. The interviews with the Facility Director and the Facility Investigator confirmed that residents are informed of the outcome of the investigation into their allegation verbally. The interview with the PC indicated that they had created a form that they would utilize in the near future related to notifying residents of the outcome of their investigation. The interview with the resident who alleged to have reported a PREA allegation indicated she was not informed of the outcome of the investigation; however, her allegation was of sexual harassment rather than sexual abuse and as such, per the standard, the notification is not required. Based on a lack of documented evidence of the reported notifications, as well as information from interviews, this provision of the standard appears to not be in compliance and requires corrective action.

115.273 (b): The Austin Police Department is responsible for conducting all criminal and certain administrative investigations for the facility. The Police Department provides the residents with a copy of the case number so they can inquire about their case. If the resident is still in the custody of the facility, the Police Department will provide a copy of the report to the facility who will then provide the outcome to the resident. The PAQ indicated that there was one investigation completed within the previous twelve months by an outside agency. A review of the investigation indicated that both residents departed the facility prior to the completion of the investigation, however the investigating Officer provided the case number to the residents prior to their departure.

115.273 (c): The Criminal and Administrative Agency Investigation Policy describes the process for reporting investigative information to residents. Specifically, it indicates that following an investigation into a resident's sexual abuse allegation against a staff member, the agency will inform the resident as to whether the staff member is no longer posted within the residents unit, the staff member is no longer employed at the facility, if the agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility or the agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility. The PAQ indicated that there have been no substantiated or unsubstantiated allegations of sexual abuse committed by a staff member against a resident in the previous twelve months.

115.273 (d): The Criminal and Administrative Agency Investigation Policy describes the process for reporting investigative information to residents. Specifically, it indicates that following an investigation into a resident's sexual abuse allegation by another resident, the agency will inform the resident as to whether the alleged abuser has been indicted on a charge related to sexual abuse within the facility or if the alleged abuser has been convicted on a charge related to sexual abuse within the facility. The PAQ indicated that there have been no substantiated or unsubstantiated allegations of sexual abuse

committed by a resident against another resident in the previous twelve months. However, a review of the allegations indicated that there was one substantiated administrative resident-on-resident sexual abuse investigation. The perpetrator was removed from the program and was transferred to a facility for mental health issues. The criminal case was deemed unfounded and as such no charges were filed.

115.73 (e): The Criminal and Administrative Agency Investigation Policy describes the process for reporting investigative information to residents. Specifically, it states that all notifications or attempted notification would be documented. The PAQ did not indicated if there were notifications made during the audit period, however there were four sexual abuse investigations completed within the previous twelve months. A review of the four sexual abuse investigations (one criminal and one administrative for the same case and one that did not rise to the level of PREA) indicated that residents were not documented to have been informed of the outcome of the investigation. The interviews with the Facility Director and the Facility Investigator confirmed that residents are informed of the outcome of the investigation into their allegation verbally. The interview with the PC indicated that they had created a form that they would utilize in the near future related to notifying residents of the outcome of their investigation. The interview with the resident who alleged to have reported a PREA allegation indicated she was not informed of the outcome of the investigation; however, her allegation was of sexual harassment rather than sexual abuse and as such, per the standard, the notification is not required. Based on a lack of documented evidence of the reported notifications, as well as information from interviews, this provision of the standard appears to not be in compliance and requires corrective action.

115.73 (f): This provision is not required to be audited.

While subsections (b)-(d) of this standard appear to be compliant based on a review of the PAQ, the Criminal and Administrative Agency Investigation Policy, and interviews with Facility Director and Investigator, the overall compliance of this standard is not met due to provision (a) and (e). While a policy is in place requiring residents to be notified of the outcome of the investigation, interviews with the Facility Director, PC and the Investigator confirmed that they are done verbally only. A review of the four investigations indicated there was no documentation that the residents were provided notification of the outcome of their investigation (verbally or in writing). Interviews indicated that outcomes are provided verbally, however no other evidence corroborated this practice. The PC indicated a form was created to document all sections of this standard, however it was not yet put into practice. Based on documentation and interviews, this standard is not compliant and requires corrective action.

Corrective Action:

The auditor recommends that the newly created form is implemented as soon as possible. The auditor recommends the resident be responsible for signing that they received this information on the form and a staff member sign indicating they provided the outcome and witnessed the resident sign the form. Additionally, the auditor recommends a copy of this form is maintained with the investigation. The auditor will require the facility to provide at least three examples of resident notifications to ensure this practice is now systematic.

Verification of Corrective Action since the Interim Audit Report

The auditor gathered and analyzed the following additional evidence provided by the facility during the corrective action period relevant to the requirements in this standard.

Additional Documents:

1. Notice of PREA Investigation Outcome

After the issuance of the Interim Audit Report, the auditor and the facility discussed the recommended corrective action for this standard. The auditor spoke to the PREA Coordinator and Facility Director via phone for an update regarding the implementation of the corrective action. The facility created the Notice of PREA Investigative Outcome form related to provision (e). The form indicates the date of the incident, the name of the resident involved and the outcome of the investigation. The form has a place for the resident to sign indicating they have been informed of the outcomes, as well as a place for the staff member providing the notification information to sign. The Facility Director indicated that the resident will receive a copy of the form and the original will be placed in the investigative file. The auditor received the required three notification outcomes confirming that residents are informed of the outcome of their investigation in writing. Based on a review of this information, subsection (e) of this standard has been corrected and this standard has been met.

DISCIPLINE

Standard 115.276: Disciplinary sanctions for staff

115.276 (a)

- Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? ☒ Yes ☐ No

115.276 (b)

- Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse? ☒ Yes ☐ No

115.276 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories? ☒ Yes ☐ No

115.276 (d)

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies unless the activity was clearly not criminal? ☒ Yes ☐ No

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Disciplinary Sanctions for Staff Policy
3. Investigative Reports

Findings (By Provision):

115.276 (a): The Disciplinary Sanctions for Staff Policy describes the process for disciplinary sanctions against staff. Specifically, they indicate that staff are subject to disciplinary sanctions up to and including termination for violating the sexual abuse or sexual harassment policies.

115.276 (b): The Disciplinary Sanctions for Staff Policy indicates that termination will be the presumptive disciplinary sanction for staff who engage in the sexual abuse. The PAQ indicated that there were no staff who violated the sexual abuse and sexual harassment policies. Additionally, there have been no staff who were terminated or resigned prior to termination for violating the sexual abuse and sexual harassment policies within the previous twelve months. A review of the investigative reports confirms that there were no substantiated allegations of staff on resident sexual abuse.

115.276 (c): The Disciplinary Sanctions for Staff Policy describes the process for disciplinary sanctions against staff. Specifically, it illustrates that disciplinary sanctions for violations of the agency's sexual abuse and sexual harassment policies shall be commensurate with the nature and circumstances of the act, the staff member's disciplinary history and the sanctions imposed for comparable offense by other staff members with similar histories. The PAQ indicated that there had been no staff that were disciplined, short of termination, for violating the sexual abuse and sexual harassment policies within the previous twelve months. A review of the investigative reports confirms that there were no substantiated allegations of staff on resident sexual abuse.

115.276 (d): The Disciplinary Sanctions for Staff Policy indicates that staff who are terminated for violating the sexual abuse or sexual harassment policies, or staff who resign prior to being terminated, will be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. The PAQ indicated that there had been no staff that were disciplined for violating the sexual abuse and sexual harassment policies within the previous twelve months. The PAQ indicated that there have not been any staff members reported to law enforcement or relevant licensing bodies.

Based on a review of the PAQ, the Disciplinary Sanctions for Staff Policy and sexual abuse investigative reports, this standard appears to be compliant.

Standard 115.277: Corrective action for contractors and volunteers

115.277 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies unless the activity was clearly not criminal? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? ☒ Yes ☐ No

115.277 (b)

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Documents:

1. Pre-Audit Questionnaire
2. Corrective Action for Contractors and Volunteers
3. Investigative Reports

Interviews:

1. Interview with the Facility Director

Findings (By Provision):

115.77 (a): The Corrective Action for Contractors and Volunteers describes the process for corrective action for volunteers and contractors. Specifically, it states that any contractor or volunteer who engages in sexual abuse will be prohibited from contact with residents and will be reported to law enforcement, unless the activity was clearly not criminal, and to relevant licensing bodies. The PAQ indicated that within the previous twelve months there have been no contractors or volunteers who have been reported to law enforcement or relevant licensing bodies and in fact there have been no contractors or volunteers as subjects of investigations of sexual abuse or sexual harassment of residents. A review of investigative reports confirms that no substantiated allegations of sexual abuse involved a contractor or volunteer.

115.77 (b): The Corrective Action for Contractors and Volunteers and the PAQ indicated that the agency takes remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of sexual abuse or sexual harassment policies. The interview with the Facility Director indicated that any violation of the sexual abuse and sexual harassment policies would result in the volunteer or contractor not being authorized to return to the facility. Additionally, HR of their organization would be notified and the allegation would be reported and investigated.

Based on a review of the PAQ, the Corrective Action for Contractors and Volunteers, investigative reports and information from the interview with the Facility Director, this standard appears to be compliant.

Standard 115.278: Interventions and disciplinary sanctions for residents

115.278 (a)

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, are residents subject to disciplinary sanctions pursuant to a formal disciplinary process? ☒ Yes ☐ No

115.278 (b)

- Are sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories? ☒ Yes ☐ No

115.278 (c)

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior? ☒ Yes ☐ No

115.278 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to require the offending resident to participate in such interventions as a condition of access to programming and other benefits? ☒ Yes ☐ No

115.278 (e)

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? ☒ Yes ☐ No

115.278 (f)

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? ☒ Yes ☐ No

115.278 (g)

- If the agency prohibits all sexual activity between residents, does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire

2. Disciplinary Sanctions for Residents Policy
3. Investigative Reports
4. Disciplinary Report/Documents

Interviews:

1. Interview with the Facility Director
2. Interview with Medical and Mental Health Staff

Findings (By Provision):

115.278 (a): The Disciplinary Sanctions for Residents Policy describes the disciplinary process for residents. Specifically, it states that residents will be subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident on resident sexual abuse or following a finding of guilt from a criminal investigation. The PAQ indicated there has been one administrative findings of resident on resident sexual abuse within the previous twelve months. A review of the investigative report and the disciplinary documents, indicates the resident's mental health (and not taking her prescribed medication) contributed to the incident and as such the resident was terminated from the program and transferred to a facility that could accommodate her mental health issues. While a disciplinary process ensued, the mental health of the resident indicated formal discipline was not appropriate.

115.278 (b): The Disciplinary Sanctions for Residents Policy describes the disciplinary process for residents. Specifically, it indicates that the sanctions will commensurate with the nature and circumstances of the abuse committed, the residents' disciplinary history and sanctions imposed for comparable offenses by residents with similar histories. The PAQ indicated there has been one administrative findings of resident on resident sexual abuse within the previous twelve months. A review of the investigative report and the disciplinary documents, indicates the resident's mental health (and not taking her prescribed medication) contributed to the incident and as such the resident was terminated from the program and transferred to a facility that could accommodate her mental health issues. While a disciplinary process ensued, the mental health of the resident indicated formal discipline was not appropriate. The interview with the Facility Director indicated that the resident abuser would be discharged from the program and would be subject to criminal charges of violating their probation, if applicable.

115.278 (c): The Disciplinary Sanctions for Residents Policy describes the disciplinary process for residents. Specifically, it indicates that the disciplinary process will consider whether the resident's mental illness or mental disability contributed to the behavior when determining what sanctions, if any, should be imposed. The PAQ indicated there has been one administrative findings of resident on resident sexual abuse within the previous twelve months. A review of the investigative report and the disciplinary documents, indicates the resident's mental health (and not taking her prescribed medication) contributed to the incident and as such the resident was terminated from the program and transferred to a facility that could accommodate her mental health issues. While a disciplinary process ensued, the mental health of the resident indicated formal discipline was not appropriate. The interview with the Facility Director indicated that the resident abuser would be discharged from the program and would be subject to criminal charges of violating their probation, if applicable. The Director indicated prior to any discipline the resident's mental health would be taken into consideration. The Director indicated this was what happened with the resident involved in the substantiated allegation within the previous twelve months.

115.278 (d): The Disciplinary Sanctions for Residents Policy describes the disciplinary process for residents. Specifically, it indicates that the agency will offer therapy, counseling and other interventions to correct underlying reasons or motivations for the abuse and will consider whether to require the abuser to participate in these interventions as a condition of access to programming and other benefits. The PAQ indicated there has been one administrative findings of resident on resident sexual abuse within the previous twelve months. The PAQ indicated there has been one administrative findings of resident on resident sexual abuse within the previous twelve months. A review of the investigative report and the disciplinary documents, indicates the resident's mental health (and not taking her prescribed medication) contributed to the incident and as such the resident was terminated from the program and transferred to a facility that could accommodate her mental health issues. While a disciplinary process ensued, the mental health of the resident indicated formal discipline was not appropriate. Interviews with mental health staff indicated that they do offer therapy, counseling and other services designed to address and correct underlying issues, but they do not require the resident participation as a condition of access to programming and other benefits.

115.278 (e): The Disciplinary Sanctions for Residents Policy describes the disciplinary process for residents. Specifically, it indicates that the facility may discipline a resident for sexual contact with staff only upon finding that the staff member did not consent. There have been no instances where residents have been disciplined for sexual contact with staff.

115.278 (f): The Disciplinary Sanctions for Residents Policy describes the disciplinary process for residents. Specifically, it indicates that residents will not be disciplined for falsely reporting an incident or lying if the sexual abuse allegation is made in good faith based upon reasonable belief that the alleged conduct occurred. The policy indicates that the Austin Police Department will be notified of any incidents of false allegations to determine if criminal charges will be filed. There have been no instances where residents have been disciplined for falsely reporting an incident of sexual abuse or sexual harassment.

115.78 (g): The Disciplinary Sanctions for Residents Policy describes the disciplinary process for residents. Specifically, it indicates that residents are prohibited from all sexual activity and as such can be disciplined. Consensual sexual activity does not constitute a PREA allegation.

Based on a review of the PAQ, the Disciplinary Sanctions for Residents Policy, investigative reports, disciplinary documents and information from interviews with the Facility Director and mental health care staff, this standard appears to be compliant.

MEDICAL AND MENTAL CARE

Standard 115.282: Access to emergency medical and mental health services

115.282 (a)

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment?
  ☒ Yes ☐ No

115.282 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do security staff first responders take preliminary steps to protect the victim pursuant to § 115.262? ☒ Yes ☐ No

- Do security staff first responders immediately notify the appropriate medical and mental health practitioners? ☒ Yes ☐ No

115.282 (c)

- Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate? ☒ Yes ☐ No

115.282 (d)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Access to Emergency Medical and Mental Health Services Policy
3. Medical/Mental Health Documents

Interviews:

1. Interview with Staff Responsible for Risk Screening
2. Interview with Medical and Mental Health Staff

Site Review Observations:

1. Observations of Risk Screening Area

Findings (By Provision):

115.282 (a): The Access to Emergency Medical and Mental Health Services Policy describes residents' access to emergency medical and mental health treatment. Specifically, it states that resident victims of sexual abuse receive timely and unimpeded access to emergency medical treatment and crisis

intervention services as determined by the medical and mental health practitioners and that the nature and scope of services will be determined by practitioners based on their professional judgement. A review of medical and mental health documents from the allegations of sexual abuse indicated that the two victims did not receive medical services as the allegations did not rise to the level of requiring medical services. However, all both did see mental health within a week of their allegation for a trauma follow-up. During the tour, the auditor noted that the medical area consisted of two rooms (both with doors), one where exams were able to be performed and another with files and office space for the staff. The medical area was private and allowed for adequate confidentiality. The interview with residents who reported sexual harassment indicate that she was seen by mental health staff within two weeks. Interviews with medical and mental health care staff confirm that residents receive timely services, typically immediately or within 24 hours of reporting. They also advised that services are based on their professional judgement, but also current policy and procedure and applicable laws.

115.282 (b): The Access to Emergency Medical and Mental Health Services Policy and the PAQ indicated that if no qualified medical or mental health practitioners were on duty at the time of a report of recent abuse, that security staff first responders would take the preliminary steps to protect the victim and notify the appropriate medical and mental health services (call 911). A review of medical and mental health documents from the allegations of sexual abuse indicated that the two victims did not receive medical services as the allegations did not rise to the level of requiring medical services. However, all both did see mental health within a week of their allegation for a trauma follow-up. The interviews with first responders indicated the resident would be immediately separated and a supervisor would be contacted to take the next necessary steps, to include, getting the resident the required medical attention.

115.282 (c): The Access to Emergency Medical and Mental Health Services Policy describe residents' access to emergency medical and mental health treatment. Specifically, they indicate that resident victims of sexual abuse receive timely access to emergency contraception and sexually transmitted infection prophylaxis. A review of medical and mental health documents from the allegations of sexual abuse indicated that the two victims did not receive medical services as the allegations did not rise to the level of requiring medical services. However, all both did see mental health within a week of their allegation for a trauma follow-up. The interview with the resident who alleged sexual harassment was not applicable as not abuse/penetration occurred. Interviews with medical and mental health care staff confirm that residents receive timely information about access to emergency contraception and sexual transmitted infection prophylaxis.

115.282 (d): The Access to Emergency Medical and Mental Health Services Policy describes residents' access to emergency medical and mental health treatment. Specifically, it states that resident victims of sexual abuse will receive treatment services without financial cost and regardless whether the victim names the alleged abuser or cooperates with any investigation. Interviews with the resident who reported sexual harassment indicated that she was not charged for any medical or mental health services.

Based on a review of the PAQ, the Access to Emergency Medical and Mental Health Services Policy, medical and mental health documents and information from interviews with medical and mental health care staff, this standard appears to be compliant.

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

115.283 (a)

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility? ☒ Yes ☐ No

115.283 (b)

- Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody? ☒ Yes ☐ No

115.283 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? ☒ Yes ☐ No

115.283 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if "all-male" facility. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☒ Yes ☐ No ☐ NA

115.283 (e)

- If pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if "all-male" facility. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☒ Yes ☐ No ☐ NA

115.283 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? ☒ Yes ☐ No

115.283 (g)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

115.283 (h)

- Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers Policy
3. Medical and Mental Health Documents
4. Investigative Reports

Interviews:

1. Interview with Medical and Mental Health Staff
2. Interview with Residents who Reported Sexual Abuse
3. Interview with Security Staff and Non-Security Staff First Responders

Site Review Observations:

1. Observations of Medical Treatment Areas

Findings (By Provision):

115.283 (a): The Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers Policy describes ongoing medical and mental health care for sexual abuse victims and abusers. Specifically, it states that the facility will offer medical and mental health evaluations and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup or juvenile facility. During the tour, the auditor noted that the medical area consisted of two rooms (both with doors), one where exams were able to be performed and another with files and office space for the staff. The medical area was private and allowed for adequate confidentiality.

115.283 (b): The Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers Policy describes ongoing medical and mental health care for sexual abuse victims and abusers. Specifically, it states that evaluations and treatments of such victims will include; follow up services, treatment plans, and when necessary, referrals for continued care following transfer or release from custody. A review of medical and mental health documents indicate that resident victims of sexual abuse were offered services via mental health and offered continuing services if needed. The interview with the resident who reported harassment indicated that she was seen by mental health within two weeks and that she has follow up with mental health routinely. Interviews with mental health care staff confirmed that follow up services would be offered. A few of the services include; trauma assessment, crisis intervention services, long term counseling and resources/referrals for community services.

115.283 (c): The Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers Policy describes ongoing medical and mental health care for sexual abuse victims and abusers. Specifically, it

states that medical and mental health services will be consistent with the community level of care. A review of medical and mental health documents for resident victims indicates that three victims were provided mental health services with licensed mental health professionals. All medical and mental health staff are required to have the appropriate credentials and licensures. The facility utilizes the local hospital for forensic medical examinations. Interviews with medical and mental health care staff confirm that the services they provide are consistent with the community level of care.

115.283 (d): The Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers Policy indicates that resident victims of sexually abusive vaginal penetration while incarcerated will be offered pregnancy tests. A review of the sexual abuse investigations evidenced that there were no sexual abuse allegations that involved vaginal penetration.

115.283 (e): Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers Policy indicates that if pregnancy results from the conduct described in section d of this standard, such victims will receive timely and comprehensive information about and timely access to all lawful pregnancy related medical services. A review of the sexual abuse investigations evidenced that there were no sexual abuse allegations that involved vaginal penetration. Interviews with medical staff confirm that residents would receive information on pregnancy related medical services, however the resident would be transferred to a facility that could provide better pregnancy related medical care.

115.283 (f): Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers Policy describes ongoing medical and mental health care for sexual abuse victims and abusers. Specifically, it states that victims of sexual abuse while incarcerated will be offered tests for sexually transmitted infections as medically appropriate. A review of investigative reports indicated that no allegations involving penetration of any kind were reported in the previous twelve months, and as such no tests were required to be offered. Interviews did indicate however, that these services would more than likely be provided at the local hospital.

115.283 (g): Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers Policy describes residents' access to emergency medical and mental health treatment. Specifically, it states that resident victims of sexual abuse will receive treatment services without financial cost and regardless whether the victim names the alleged abuser or cooperates with any investigation. The interview with the resident who reported sexual harassment indicated that she was not charged for any medical or mental health services.

115.283 (h): Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers Policy indicates that a mental health evaluation of all known offender-on-offender abusers shall be attempted within 60 days of learning of the abuse and treatment will be offered when deemed appropriate in accordance with policy. A review of mental health documentation indicated that one of the two abusers was offered a mental health follow up, the other abuser was transferred to another facility to provide comprehensive mental health services as her mental health was part of why she committed abuse. Interviews with medical and mental health staff confirm that resident-on-resident abusers would be offered mental health services.

Based on a review of the PAQ, Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers Policy, medical and mental health documentation, investigative reports and information from interviews with residents who reported sexual harassment and medical and mental health care staff, this standard appears to be compliant.

DATA COLLECTION AND REVIEW

Standard 115.286: Sexual abuse incident reviews

115.286 (a)

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded? ☐ Yes ☒ No

115.286 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? ☐ Yes ☒ No

115.286 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? ☐ Yes ☒ No

115.286 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☐ Yes ☒ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☐ Yes ☒ No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☐ Yes ☒ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☐ Yes ☒ No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☐ Yes ☒ No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.286(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☐ Yes ☒ No

115.286 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? ☐ Yes ☒ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Documents:

1. Pre-Audit Questionnaire
2. Sexual Abuse Incident Review Policy
3. Sexual Abuse Incident Review Form
4. Investigative Reports

Interviews:

1. Interview with the Facility Director
2. Interview with the PREA Coordinator
3. Interview with Incident Review Team

Findings (By Provision):

115.286 (a): The Sexual Abuse Incident Review Policy outlines information related to sexual abuse incident reviews. Specifically, it states that the facility will conduct sexual abuse incident reviews of every sexual abuse investigation, except for those allegations that are deemed to be unfounded. The PAQ did not indicated that there were any reviews completed within the previous twelve months. A review of the sexual abuse investigations determined that three allegations were determined to be unfounded (one did not rise to the level of PREA after review by the auditor), while one was determined to be substantiated. The interview with the PC and the Facility Director indicated that there was not previously a formal process to complete these reviews, however they are now done one a month during weekly management meetings. A review of documents indicated that a sexual abuse incident review was not completed for the substantiated allegation. As such, this provision is not met and corrective action is required.

115.286 (b): The Sexual Abuse Incident Review Policy outlines information related to sexual abuse incident reviews. Specifically, it states that the facility will conduct an incident review of all sexual abuse allegations ordinarily within 30 days of the conclusion of the investigation. The PAQ did not indicated that there were any reviews completed within the previous twelve months. A review of the sexual abuse investigations determined that three allegations were determined to be unfounded (one did not rise to the level of PREA after review by the auditor), while one was determined to be substantiated. The interview with the PC and the Facility Director indicated that there was not previously a formal process to complete these reviews, however they are now done one a month during weekly management meetings. A review of documents indicated that a sexual abuse incident review was not completed for the substantiated allegation. As such, this provision is not met and corrective action is required.

115.286 (c): The Sexual Abuse Incident Review Policy outlines information related to sexual abuse incident reviews. Specifically, it states that the review team will consists of upper management officials, with input from line supervisors, investigators and medical and mental health. The interview with the Facility Director confirmed that the management team is the same team that conducts the sexual abuse incident reviews. The Facility Director indicated that previously there was not a formal review process

and as such prior reviews were not completed by the appropriate staff. A review of documents indicated that a sexual abuse incident review was not completed for the substantiated allegation. As such, this provision is not met and corrective action is required.

115.286 (d): The Sexual Abuse Incident Review Policy as well as the Sexual Abuse Incident Review Form outlines information required to be completed related to sexual abuse incident reviews. Specifically, it includes: consider whether the allegation or investigation indicates a need to change policy or practice; whether the incident or allegation was motivated by race, ethnicity, gender identity or sexual preference (identified or perceived), gang affiliation, or if it was motivated by other group dynamics; examine the area where the incident allegedly occurred to assess whether there were any physical barriers; assess the staffing levels; assess video monitoring technology and prepare a report of its findings to include any recommendations for improvement. The report is forwarded to the Facility Administrator, PREA Coordinator, Division Director and Director. Interviews indicated that the team would work together to ensure they had every detail possible to make any necessary changes for prevention. The interview with the PC and the Facility Director indicated that this is a new process. A review of documents indicated that a sexual abuse incident review was not completed for the substantiated allegation. As such, this provision is not met and corrective action is required.

115.86 (e): The Sexual Abuse Incident Review Policy outlines information related to sexual abuse incident reviews. Specifically, it states that the facility will implement the recommendations for improvement or document the reasons for not doing so. The PAQ indicated that the facility would implement the recommendations for improvement or document reasons for not doing so. The interview with the PC and the Facility Director indicated that there was not previously a formal process to complete these reviews, however they are now done one a month during weekly management meetings. A review of documents indicated that a sexual abuse incident review was not completed for the substantiated allegation. As such, this provision is not met and corrective action is required.

Based on a review of the PAQ, the Sexual Abuse Incident Review Policy, the Sexual Abuse Incident Review Form, investigative reports and information from interviews with the Facility Director, the PC and a member of the sexual abuse incident review team, the auditor determined that this standard is not met. While the facility has implemented a new policy and procedure for sexual abuse incident reviews, this was not previously being done and as such, the one substantiated sexual abuse allegation did not have a review completed. Based on this information corrective action is required in order for the auditor to confirm the newly implemented practice is being completed and is systematic.

Corrective Action:

The facility must complete the Sexual Abuse Incident Review Form for each sexual abuse allegation that is determined to be substantiated or unsubstantiated within 30 day of the completion of the investigation. The form includes all the requirements in provisions (d) and (e). The management team consists of the required staff in provision (c), however it will need to be documented that these staff participated in the review. The facility will need to forward all completed sexual abuse incident reviews to the auditor over the next 90 days.

Verification of Corrective Action since the Interim Audit Report

The auditor gathered and analyzed the following additional evidence provided by the facility during the corrective action period relevant to the requirements in this standard.

Additional Documents:

1. SMART Facility PREA Incident Review

After the issuance of the Interim Audit Report, the auditor and the facility discussed the recommended corrective action for this standard. The auditor spoke to the PREA Coordinator and Facility Director via phone for an update regarding the implementation of the corrective action. The facility utilized the SMART Facility PREA Incident Review (their version of the Sexual Abuse Incident Review Form) related to provision (e). The form includes the date the incident was reported, the date the investigation was concluded, the outcome of the investigation, whether the allegation indicates a need for policy change, whether it was motivated by race, gender, ethnicity, etc., whether there was any physical barriers, whether video monitoring technology was in the area, whether staffing levels were adequate, whether video monitoring technology should be deployed or augmented, whether the victim was notified of the outcome of the investigation and whether there are any recommendations or actions taken due to the incident. The auditor received two completed forms. The reviews were completed within 30 days of the competition of the investigation and included all components required of the review. Based on a review of this information, subsection (e) of this standard has been corrected and this standard has been met.

Standard 115.287: Data collection

115.287 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? ☒ Yes ☐ No

115.287 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually? ☒ Yes ☐ No

115.287 (c)

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? ☒ Yes ☐ No

115.287 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews? ☒ Yes ☐ No

115.287 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) ☒ Yes ☐ No ☐ NA

115.287 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire

2. Data Collection Policy
3. Aggregated Data

Findings (By Provision):

115.287 (a): The Data Collection Policy outlines how PREA data is collected. Specifically, it states that the agency will collect accurate uniform data for every allegation of sexual abuse and sexual harassment. It also indicates that the data will include at minimum, data to answer questions on the Survey of Sexual Victimization. A review of collected data confirmed that the agency utilizes the definitions set forth in the PREA standards. Data is collected from incident reports (if completed) and investigative reports.

115.287 (b): The Sexual Abuse Incident Review Policy outlines how PREA data is collected. A review of collected data confirmed that the agency aggregates sexual abuse data at least annually through the Gateway Foundation.

115.287 (c): The Sexual Abuse Incident Review Policy outlines how PREA data is collected. Specifically, it states that the agency will collect accurate uniform data for every allegation of sexual abuse and sexual harassment. It also indicates that the data will include at minimum, data to answer questions on the Survey of Sexual Victimization. A review of collected data confirmed that the agency utilizes the definitions set forth in the PREA standards. Data is collected from incident reports (if completed) and investigative reports.

115.287 (d): The Sexual Abuse Incident Review Policy outlines how PREA data is collected. Specifically, it states that the agency will maintain, review and collect data as needed from available incident-based documents. At the facility level data is collected through reports.

115.287 (e): The Sexual Abuse Incident Review Policy outlines how PREA data is collected. Specifically, it states that incident-based data will be collected from all private facilities with which the agency contracts with for confinement of its residents. The TDCJ collects incident-based and aggregated data from every private facility with which it contracts for the confinement of its resident. This data is included in the annual report but is not reported in the Survey of Sexual Victimization as outlined by the Department of Justice.

115.287 (f): The PAQ indicated that the agency provides the Department of Justice with data from the previous calendar year to the Department of Justice no later than June 30th.

Based on a review of the PAQ, the Data Collection policy and the aggregated data, this standard appears to be compliant.

Standard 115.288: Data review for corrective action

115.288 (a)

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response

policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

115.288 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse ☒ Yes ☐ No

115.288 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.288 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Data Review for Corrective Action

Interviews:

1. Interview with the Agency Head Designee
2. Interview with the PREA Coordinator

Findings (By Provision):

115.288 (a): The Data Review for Corrective Action Policy and the PAQ indicated that the agency reviews data annually in order to asses and improve the effectiveness of its sexual abuse prevention, detection and response policies and training. The review includes: identifying problem areas, taking corrective action on an ongoing basis and preparing an annual report of its findings and any corrective

action. A review of the TDCJ PREA annual reports indicates that reports break down the collected data by types of cases, location of incidents, outcome of the investigations as well as compares the data from the current year with prior years. Additionally, it includes problem areas and corrective action. Interviews with the Agency Head and PC confirmed that the report is done annually, that leadership meets to discuss the data and all allegations to determine if any improvements are needed. The Agency Head Designee indicated that the data is used to determine any patterns or weaknesses to make any necessary changes or adjustments. Additionally, the PC confirmed that the Gateway Foundation also has a report on their website that includes the facility's information (http://gatewaycorrections.org/about/annual-reports/).

115.288 (b): The Data Review for Corrective Action Policy and the PAQ indicated that the agency's annual report includes a comparison of the current year's data and corrective actions with those from prior years and provides an assessment of the progress. A review of TDCJ PREA annual reports indicates that reports break down the collected data by types of cases, location of incidents, outcome of the investigations as well as compares the data from the current year with prior years. Additionally, it includes problem areas and corrective action.

115.288 (c): The Data Review for Corrective Action Policy and the PAQ indicated that the agency's annual report is approved by the agency Director and made available to the public through its website. The interview with the Agency Head Designee confirmed that the report is approved by the TDCJ Agency Head and after it is approved it is placed on their website (https://www.tdcj.texas.gov/publications/index.html) for the public to review. Additionally, the Gateway Foundation also has an annual report that is published on their website for public review. A review of both the websites confirmed that the both current annual reports are available to the public online.

115.288 (d): The agency does not include any identifiable information or sensitive information on its annual report and as such does not require any information to be redacted.

Based on a review of the PAQ, the Data Review for Corrective Action Policy, the TDCJ PREA annual report and the website, and the Gateway Foundation annual report on their website, this standard appears to be compliant.

Standard 115.289: Data storage, publication, and destruction

115.289 (a)

- Does the agency ensure that data collected pursuant to § 115.287 are securely retained? ☒ Yes ☐ No

115.289 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.289 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

115.289 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Documents:

1. Pre-Audit Questionnaire
2. Data Storage, Publication and Destruction
3. Facility Brochure

Interviews:

1. Interview with the PREA Coordinator

Findings (By Provision):

115.289 (a): The Data Storage, Publication and Destruction Policy describes the data storage, publication and destruction information related to sexual abuse and sexual harassment allegations. Specifically, it states that the agency will ensure all data is securely retained. The PAQ as well as the interview with the PREA Coordinator confirmed that data is securely retained by their information technology staff.

115.289 (b): The Data Review for Corrective Action Policy describes the data storage, publication and destruction information related to sexual abuse and sexual harassment allegations. Specifically, it states that the agency will make all aggregated sexual abuse data readily available to the public annually through its website or other means. The facility does not currently have a website, however aggregate data for the facility is found on the Gateway Foundations website under their annual report (http://gatewaycorrections.org/prea/reporting/) as well as on the facility brochure that is available to the public via request or in the lobby of the facility.

115.289 (c): The facility does not include any identifiable information or sensitive information on its brochure and as such does not require any information to be redacted. A review of the annual report confirmed that no personal identifiers were publicly available.

115.289 (d): The PAQ and the Data Review for Corrective Action Policy indicates that the agency maintains sexual abuse data that is collected for at least ten years after the date of initial collection. A review of the TDCJ's agency website confirmed that data is available from 2009 to present.

Based on a review of the PAQ, the Data Review for Corrective Action Policy, the facility brochure, Gateway Foundation's website, TDCJ's website and information obtained from the interview with the PREA Coordinator, this standard appears to be compliant.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*) ☒ Yes ☐ No

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard*.) ☒ Yes ☐ No

- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? ☒ Yes ☐ No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? ☒ Yes ☐ No

115.401 (m)

- Was the auditor permitted to conduct private interviews with residents? ☒ Yes ☐ No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Findings (By Provision):

115.401 (a). The facility is part of the Texas Department of Criminal Justice. All TDCJ facilities were audited in the previous three-year audit cycle.

115.401 (b): The facility is part of the Texas Department of Criminal Justice. The TDCJ has a schedule for all their facilities to be audited within the three-year cycle, with one third being audited in each cycle. The facility is being audited in the first year of the three-year cycle.

115.401 (h) – (m): The auditor had access to all areas of the facility; was permitted to receive and copy any relevant policies, procedure or documents; was permitted to conduct private interviews and was able to receive confidential information/correspondence from residents.

Standard 115.403: Audit contents and findings

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

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

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

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

Findings (By Provision):

115.401 (a). This facility has never been previously audited.

AUDITOR CERTIFICATION

I certify that:

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

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

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

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.[3] Auditors are not permitted to submit audit reports that have been scanned.[4] See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Kendra Prisk April 14, 2020

Auditor Signature **Date**

[3] See additional instructions here: https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110 .

[4] See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.