PREA Facility Audit Report: Final

Name of Facility: Shamar Hope Haven Residential Treatment Center
Facility Type: Juvenile
Date Interim Report Submitted: NA
Date Final Report Submitted: 01/13/2024

Auditor Certification	
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.	☑
I have not included in the final report any personally identifiable information (PII) about any inmate/resident/detainee or staff member, except where the names of administrative personnel are specifically requested in the report template.	☑
Auditor Full Name as Signed: Jerome K Williams	**Date of Signature:** 01/13/2024

AUDITOR INFORMATION	
Auditor name:	Williams, Jerome
Email:	wjerome27@yahoo.com
Start Date of On-Site Audit:	11/29/2023
End Date of On-Site Audit:	12/01/2023

FACILITY INFORMATION	
Facility name:	Shamar Hope Haven Residential Treatment Center
Facility physical address:	2913 Wheeler Avenue, Houston, Texas - 77004
Facility mailing address:	

Primary Contact	
Name:	Sharon Evans
Email Address:	EvansSevans@aol.com
Telephone Number:	7139428822

Superintendent/Director/Administrator	
Name:	Sharon A Evans
Email Address:	EvansSevans@aol.com
Telephone Number:	17135303260

Facility PREA Compliance Manager	
Name:	Lisa Clay
Email Address:	shhtxtm@aol.com
Telephone Number:	O: 713-942-8822

Facility Characteristics	
Designed facility capacity:	13
Current population of facility:	7
Average daily population for the past 12 months:	5
Has the facility been over capacity at any point in the past 12 months?	No
Which population(s) does the facility hold?	Males
Age range of population:	10-17
Facility security levels/resident custody levels:	LOC specialize/intense.
Number of staff currently employed at the	15

facility who may have contact with residents:	
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	5
Number of volunteers who have contact with residents, currently authorized to enter the facility:	1

AGENCY INFORMATION	
Name of agency:	Shamar Hope Haven, Inc.
Governing authority or parent agency (if applicable):	
Physical Address:	2719 Truxillo Street, Houston, Texas - 77004
Mailing Address:	
Telephone number:	

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

Agency-Wide PREA Coordinator Information			
Name:	Sharon Evans	**Email Address:**	evanssevans@aol.com

Facility AUDIT FINDINGS

Summary of Audit Findings

The OAS automatically populates the number and list of Standards exceeded, the number of Standards met, and the number and list of Standards not met.

Auditor Note: In general, no standards should be found to be "Not Applicable" or "NA." A compliance determination must be made for each standard. In rare instances where an auditor determines that a standard is not applicable, the auditor should select "Meets Standard" and include a comprehensive discussion as to why the standard is not applicable to the facility being audited.	
Number of standards exceeded:	
1	• 115.313 - Supervision and monitoring
Number of standards met:	
42	
Number of standards not met:	
0	

POST-AUDIT REPORTING INFORMATION

GENERAL AUDIT INFORMATION

On-site Audit Dates

1. Start date of the onsite portion of the audit:	2023-11-29
2. End date of the onsite portion of the audit:	2023-12-01

Outreach

10. Did you attempt to communicate with community-based organization(s) or victim advocates who provide services to this facility and/or who may have insight into relevant conditions in the facility?	(●) Yes ( ) No
a. Identify the community-based organization(s) or victim advocates with whom you communicated:	I contacted via phone the Sexual Assault Recovery Center (SARC) hotline operator who informed me of their process when they receive a phone call from a victim of sexual assault for the crisis intervention and emotional support services, whether in the community or in a facility. She indicated that they would coordinate forensic services for a victim of sexual assault with the local hospital and in this case, since this is a juvenile facility, with the Texas Children's Hospital. They would also provide advocacy services to the victim including being represented during the forensic interview after the forensic exam. She further indicated that the Facility Director would be notified if a resident reported a sexual abuse in the facility after local law enforcement had been notified.

AUDITED FACILITY INFORMATION

14. Designated facility capacity:	13
15. Average daily population for the past 12 months:	5

16. Number of inmate/resident/detainee housing units:	1
17. Does the facility ever hold youthful inmates or youthful/juvenile detainees?	○ Yes ◉ No ○ Not Applicable for the facility type audited (i.e., Community Confinement Facility or Juvenile Facility)

Audited Facility Population Characteristics on Day One of the Onsite Portion of the Audit

Inmates/Residents/Detainees Population Characteristics on Day One of the Onsite Portion of the Audit

36. Enter the total number of inmates/ residents/detainees in the facility as of the first day of onsite portion of the audit:	8
38. Enter the total number of inmates/ residents/detainees with a physical disability in the facility as of the first day of the onsite portion of the audit:	0
39. Enter the total number of inmates/ residents/detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) in the facility as of the first day of the onsite portion of the audit:	0
40. Enter the total number of inmates/ residents/detainees who are Blind or have low vision (visually impaired) in the facility as of the first day of the onsite portion of the audit:	0
41. Enter the total number of inmates/ residents/detainees who are Deaf or hard-of-hearing in the facility as of the first day of the onsite portion of the audit:	0

42. Enter the total number of inmates/ residents/detainees who are Limited English Proficient (LEP) in the facility as of the first day of the onsite portion of the audit:	0
43. Enter the total number of inmates/ residents/detainees who identify as lesbian, gay, or bisexual in the facility as of the first day of the onsite portion of the audit:	0
44. Enter the total number of inmates/ residents/detainees who identify as transgender or intersex in the facility as of the first day of the onsite portion of the audit:	0
45. Enter the total number of inmates/ residents/detainees who reported sexual abuse in the facility as of the first day of the onsite portion of the audit:	0
46. Enter the total number of inmates/ residents/detainees who disclosed prior sexual victimization during risk screening in the facility as of the first day of the onsite portion of the audit:	0
47. Enter the total number of inmates/ residents/detainees who were ever placed in segregated housing/isolation for risk of sexual victimization in the facility as of the first day of the onsite portion of the audit:	0
48. Provide any additional comments regarding the population characteristics of inmates/residents/detainees in the facility as of the first day of the onsite portion of the audit (e.g., groups not tracked, issues with identifying certain populations):	Post Covid-19 pandemic and as of this audit, this facility has only received Department of Family and Protective Services youth (DFPS or child welfare) into their residential program only instead of a combination of juvenile justice youth and child welfare youth pre Covid-19 pandemic.

Staff, Volunteers, and Contractors Population Characteristics on Day One of the Onsite Portion of the Audit	
49. Enter the total number of STAFF, including both full- and part-time staff, employed by the facility as of the first day of the onsite portion of the audit:	19
50. Enter the total number of VOLUNTEERS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	0
51. Enter the total number of CONTRACTORS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	0
52. Provide any additional comments regarding the population characteristics of staff, volunteers, and contractors who were in the facility as of the first day of the onsite portion of the audit:	The facility has hired 12 new staff in 2023 and since the Covid-19 pandemic and they have not hired any volunteers to work in the facility. One of the contractors is a Psychotherapist who provides staffing and group sessions for the DFPS youth and the other contractor is a Interpreter/Translator, whose services has not be utilized in the last 12 months because they have not admitted any resident who required interpreting or translation services.

INTERVIEWS

Inmate/Resident/Detainee Interviews

Random Inmate/Resident/Detainee Interviews

53. Enter the total number of RANDOM INMATES/RESIDENTS/DETAINEES who were interviewed:	8

54. Select which characteristics you considered when you selected RANDOM INMATE/RESIDENT/DETAINEE interviewees: (select all that apply)	☑ Age ☑ Race ☑ Ethnicity (e.g., Hispanic, Non-Hispanic) ☑ Length of time in the facility ☑ Housing assignment ☑ Gender ☐ Other ☐ None
55. How did you ensure your sample of RANDOM INMATE/RESIDENT/DETAINEE interviewees was geographically diverse?	Because the facility only had 8 residents admitted to the program and in the population on the first day of the audit, this auditor interviewed all of the resident. The diversity of the residents interviewed were of different ages, from 2 of the 5 ethnic groups, length of time in the facility and race, This is an all-male facility.
56. Were you able to conduct the minimum number of random inmate/ resident/detainee interviews?	○ Yes ◉ No
a. Explain why it was not possible to conduct the minimum number of random inmate/resident/detainee interviews:	Over the past 12 months, this facility admitted 35 youth into the residential program but since their primary population were DFPS youth, their length of stay varies i.e. short term court placement, etc. During the onsite visit on day one, there were only 8 youth in this program's population and this number did not change during the onsite visit phase.
57. Provide any additional comments regarding selecting or interviewing random inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	There were no barriers encountered when completing the random resident interviews nor was there an oversampling of the population since there were only 8 residents in their population during the onsite audit phase.

Targeted Inmate/Resident/Detainee Interviews	
58. Enter the total number of TARGETED INMATES/RESIDENTS/DETAINEES who were interviewed:	0
As stated in the PREA Auditor Handbook, the breakdown of targeted interviews is intended to guide auditors in interviewing the appropriate cross-section of inmates/residents/detainees who are the most vulnerable to sexual abuse and sexual harassment. When completing questions regarding targeted inmate/resident/detainee interviews below, remember that an interview with one inmate/resident/detainee may satisfy multiple targeted interview requirements. These questions are asking about the number of interviews conducted using the targeted inmate/ resident/detainee protocols. For example, if an auditor interviews an inmate who has a physical disability, is being held in segregated housing due to risk of sexual victimization, and disclosed prior sexual victimization, that interview would be included in the totals for each of those questions. Therefore, in most cases, the sum of all the following responses to the targeted inmate/resident/detainee interview categories will exceed the total number of targeted inmates/ residents/detainees who were interviewed. If a particular targeted population is not applicable in the audited facility, enter "0".	
60. Enter the total number of interviews conducted with inmates/residents/ detainees with a physical disability using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	This auditor reviewed the submitted PAQ, resident files, intake records and ascertained from interviews with the staff and residents that there were no residents in their population currently or in the last 12 months who had a Physical Disability during the Risk Screening. Therefore, no targeted interview protocols were utilized.

61. Enter the total number of interviews conducted with inmates/residents/ detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	This auditor reviewed the submitted PAQ, resident files, intake records and ascertained from interviews with the staff and residents that there were no residents in their population currently or in the last 12 months who had a Cognitive or Functional Disability i.e. including intellectual disability, psychiatric disability, or speech disability during the Risk Screening. Therefore, no targeted interview protocols were utilized
62. Enter the total number of interviews conducted with inmates/residents/ detainees who are Blind or have low vision (i.e., visually impaired) using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	This auditor reviewed the submitted PAQ, resident files, intake records and ascertained from interviews with the staff and residents that there were no residents in their population currently or in the last 12 months who had are Blind or Have a low vision during the Risk Screening. Therefore, no targeted interview protocols were utilized
63. Enter the total number of interviews conducted with inmates/residents/ detainees who are Deaf or hard-of-hearing using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	This auditor reviewed the submitted PAQ, resident files, intake records and ascertained from interviews with the staff and residents that there were no residents in their population currently or in the last 12 months who are Deaf or hard of hearing during the Risk Screening. Therefore, no targeted interview protocols were utilized
64. Enter the total number of interviews conducted with inmates/residents/ detainees who are Limited English Proficient (LEP) using the "Disabled and Limited English Proficient Inmates" protocol:	0

a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	This auditor reviewed the submitted PAQ, resident files, intake records and ascertained from interviews with the staff and residents that there were no residents in their population currently or in the last 12 months who are Limited in English Proficiency (LEP) during the Risk Screening. Therefore, no targeted interview protocols were utilized
65. Enter the total number of interviews conducted with inmates/residents/ detainees who identify as lesbian, gay, or bisexual using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	This auditor reviewed the submitted PAQ, resident files, intake records and ascertained from interviews with the staff and residents that there were no residents in their population currently or in the last 12 months who identified as lesbian, gay, or bisexual during the Risk Screening. Therefore, no targeted interview protocols were utilized

66. Enter the total number of interviews conducted with inmates/residents/ detainees who identify as transgender or intersex using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	This auditor reviewed the submitted PAQ, resident files, intake records and ascertained from interviews with the staff and residents that there were no residents in their population currently or in the last 12 months who identified as Transgender or Intersex during the Risk Screening. Therefore, no targeted interview protocols were utilized
67. Enter the total number of interviews conducted with inmates/residents/ detainees who reported sexual abuse in this facility using the "Inmates who Reported a Sexual Abuse" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	This auditor reviewed the submitted PAQ, resident files, intake records and ascertained from interviews with the staff and residents that there were no residents in their population currently or in the last 12 months who Reported Sexual Abuse in this Facility during the Risk Screening. Therefore, no targeted interview protocols were utilized
68. Enter the total number of interviews conducted with inmates/residents/ detainees who disclosed prior sexual victimization during risk screening using the "Inmates who Disclosed Sexual Victimization during Risk Screening" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	This auditor reviewed the submitted PAQ, resident files, intake records and ascertained from interviews with the staff and residents that there were no residents in their population currently or in the last 12 months who Disclosed Prior Sexual Victimization during the Risk Screening. Therefore, no targeted interview protocols were utilized
69. Enter the total number of interviews conducted with inmates/residents/ detainees who are or were ever placed in segregated housing/isolation for risk of sexual victimization using the "Inmates Placed in Segregated Housing (for Risk of Sexual Victimization/Who Allege to have Suffered Sexual Abuse)" protocol:	0

a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	This auditor reviewed the submitted PAQ, resident files, intake records and ascertained from interviews with the staff and residents that there were no residents in their population currently or in the last 12 months who were ever placed om Segregated Housing/Isolation for Risk of Sexual Victimization during the Risk Screening. This is a residential facility which is not programmatically designed to have and or to utilize segregated housing or isolation. Therefore, no targeted interview protocols were utilized
70. Provide any additional comments regarding selecting or interviewing targeted inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews):	There were no barriers encountered when completing the random resident interviews nor was there an oversampling of the population since there were only 8 residents in their population during the onsite audit phase.
Staff, Volunteer, and Contractor Interviews	
Random Staff Interviews	
71. Enter the total number of RANDOM STAFF who were interviewed:	11

72. Select which characteristics you considered when you selected RANDOM STAFF interviewees: (select all that apply)	☑ Length of tenure in the facility ☑ Shift assignment ☑ Work assignment ☐ Rank (or equivalent) ☑ Other (e.g., gender, race, ethnicity, languages spoken) ☐ None
If "Other," describe:	The random direct care staff interviewed were male and female, representative of each shift i.e. day, swing and overnight, work assignment i.e. transportation to from school, court appointments, etc. and their length of tenure in the facility.
73. Were you able to conduct the minimum number of RANDOM STAFF interviews?	○ Yes ◉ No
a. Select the reason(s) why you were unable to conduct the minimum number of RANDOM STAFF interviews: (select all that apply)	☐ Too many staff declined to participate in interviews. ☐ Not enough staff employed by the facility to meet the minimum number of random staff interviews (Note: select this option if there were not enough staff employed by the facility or not enough staff employed by the facility to interview for both random and specialized staff roles). ☑ Not enough staff available in the facility during the onsite portion of the audit to meet the minimum number of random staff interviews. ☐ Other

74. Provide any additional comments regarding selecting or interviewing random staff (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	The facility have employed 12 random direct care staff but one staff did not report to work for his initial and rescheduled interview due to his transportation issues i.e. vehicle breakdown and repairs. This prevented this auditor from completing the required number of random staff interviews during the onsite visit.
Specialized Staff, Volunteers, and Contractor Interviews	
Staff in some facilities may be responsible for more than one of the specialized staff duties. Therefore, more than one interview protocol may apply to an interview with a single staff member and that information would satisfy multiple specialized staff interview requirements.	
75. Enter the total number of staff in a SPECIALIZED STAFF role who were interviewed (excluding volunteers and contractors):	13
76. Were you able to interview the Agency Head?	(●) Yes ( ) No
77. Were you able to interview the Warden/Facility Director/Superintendent or their designee?	(●) Yes ( ) No
78. Were you able to interview the PREA Coordinator?	(●) Yes ( ) No
79. Were you able to interview the PREA Compliance Manager?	(●) Yes ( ) No ( ) NA (NA if the agency is a single facility agency or is otherwise not required to have a PREA Compliance Manager per the Standards)

80. Select which SPECIALIZED STAFF roles were interviewed as part of this audit from the list below: (select all that apply)	☑ Agency contract administrator ☑ Intermediate or higher-level facility staff responsible for conducting and documenting unannounced rounds to identify and deter staff sexual abuse and sexual harassment ☐ Line staff who supervise youthful inmates (if applicable) ☐ Education and program staff who work with youthful inmates (if applicable) ☐ Medical staff ☑ Mental health staff ☐ Non-medical staff involved in cross-gender strip or visual searches ☑ Administrative (human resources) staff ☐ Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) staff ☐ Investigative staff responsible for conducting administrative investigations ☐ Investigative staff responsible for conducting criminal investigations ☑ Staff who perform screening for risk of victimization and abusiveness ☐ Staff who supervise inmates in segregated housing/residents in isolation ☑ Staff on the sexual abuse incident review team ☑ Designated staff member charged with monitoring retaliation ☑ First responders, both security and non-security staff ☑ Intake staff

	☐ Other
81. Did you interview VOLUNTEERS who may have contact with inmates/ residents/detainees in this facility?	○ Yes ◉ No
82. Did you interview CONTRACTORS who may have contact with inmates/ residents/detainees in this facility?	◉ Yes ○ No
a. Enter the total number of CONTRACTORS who were interviewed:	2
b. Select which specialized CONTRACTOR role(s) were interviewed as part of this audit from the list below: (select all that apply)	☐ Security/detention ☐ Education/programming ☐ Medical/dental ☐ Food service ☐ Maintenance/construction ☒ Other
83. Provide any additional comments regarding selecting or interviewing specialized staff.	The contractors interview utilizing the Specialized Staff Interview Protocol were the Psychotherapist and the Interpreter/ Translator. The Psychotherapist facilitates the group session and participates in the staffing of these residents from the Department of Family and Protective Services. The Interpreter/Translator provided interpreting services to residents when applicable but informed this auditor that her services has not been utilized in the past 12 months due to no residents in their population requiring such.

SITE REVIEW AND DOCUMENTATION SAMPLING

Site Review

PREA Standard 115.401 (h) states, "The auditor shall have access to, and shall observe, all areas of the audited facilities." In order to meet the requirements in this Standard, the site review portion of the onsite audit must include a thorough examination of the entire facility. The site review is not a casual tour of the facility. It is an active, inquiring process that includes talking with staff and inmates to determine whether, and the extent to which, the audited facility's practices demonstrate compliance with the Standards. Note: As you are conducting the site review, you must document your tests of critical functions, important information gathered through observations, and any issues identified with facility practices. The information you collect through the site review is a crucial part of the evidence you will analyze as part of your compliance determinations and will be needed to complete your audit report, including the Post-Audit Reporting Information.

84. Did you have access to all areas of the facility?	(●) Yes ( ) No
Was the site review an active, inquiring process that included the following:	
85. Observations of all facility practices in accordance with the site review component of the audit instrument (e.g., signage, supervision practices, cross-gender viewing and searches)?	(●) Yes ( ) No
86. Tests of all critical functions in the facility in accordance with the site review component of the audit instrument (e.g., risk screening process, access to outside emotional support services, interpretation services)?	(●) Yes ( ) No
87. Informal conversations with inmates/ residents/detainees during the site review (encouraged, not required)?	(●) Yes ( ) No
88. Informal conversations with staff during the site review (encouraged, not required)?	(●) Yes ( ) No

89. Provide any additional comments regarding the site review (e.g., access to areas in the facility, observations, tests of critical functions, or informal conversations).	During the site review, there were no barriers encountered by this auditor regarding having total facility access, ability to observe and test critical functions or when engaging staff and residents in informal conversations.

Documentation Sampling

Where there is a collection of records to review-such as staff, contractor, and volunteer training records; background check records; supervisory rounds logs; risk screening and intake processing records; inmate education records; medical files; and investigative files-auditors must self-select for review a representative sample of each type of record.

90. In addition to the proof documentation selected by the agency or facility and provided to you, did you also conduct an auditor-selected sampling of documentation?	(●) Yes ( ) No
91. Provide any additional comments regarding selecting additional documentation (e.g., any documentation you oversampled, barriers to selecting additional documentation, etc.).	During the site review, this auditor did request copies of completed as well as blank documents i.e., risk screening, forms and memorandums for triangulation purposes as oversamples.

SEXUAL ABUSE AND SEXUAL HARASSMENT ALLEGATIONS AND INVESTIGATIONS IN THIS FACILITY

Sexual Abuse and Sexual Harassment Allegations and Investigations Overview

Remember the number of allegations should be based on a review of all sources of allegations (e.g., hotline, third-party, grievances) and should not be based solely on the number of investigations conducted. Note: For question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, or detainee sexual abuse allegations and investigations, as applicable to the facility type being audited.

92. Total number of SEXUAL ABUSE allegations and investigations overview during the 12 months preceding the audit, by incident type:

	# of sexual abuse allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual abuse	0	0	0	0
Staff-on-inmate sexual abuse	0	0	0	0
Total	0	0	0	0

93. Total number of SEXUAL HARASSMENT allegations and investigations overview during the 12 months preceding the audit, by incident type:

	# of sexual harassment allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual harassment	0	0	0	0
Staff-on-inmate sexual harassment	0	0	0	0
Total	0	0	0	0

Sexual Abuse and Sexual Harassment Investigation Outcomes

Sexual Abuse Investigation Outcomes

Note: these counts should reflect where the investigation is currently (i.e., if a criminal investigation was referred for prosecution and resulted in a conviction, that investigation outcome should only appear in the count for “convicted.”) Do not double count. Additionally, for question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, and detainee sexual abuse investigation files, as applicable to the facility type being audited.

94. Criminal SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

	Ongoing	Referred for Prosecution	Indicted/ Court Case Filed	Convicted/ Adjudicated	Acquitted
Inmate-on-inmate sexual abuse	0	0	0	0	0
Staff-on-inmate sexual abuse	0	0	0	0	0
Total	0	0	0	0	0

95. Administrative SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual abuse	0	0	0	0
Staff-on-inmate sexual abuse	0	0	0	0
Total	0	0	0	0

Sexual Harassment Investigation Outcomes

Note: these counts should reflect where the investigation is currently. Do not double count. Additionally, for question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, and detainee sexual harassment investigation files, as applicable to the facility type being audited.

96. Criminal SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

	Ongoing	Referred for Prosecution	Indicted/ Court Case Filed	Convicted/ Adjudicated	Acquitted
Inmate-on-inmate sexual harassment	0	0	0	0	0
Staff-on-inmate sexual harassment	0	0	0	0	0
Total	0	0	0	0	0

97. Administrative SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual harassment	0	0	0	0
Staff-on-inmate sexual harassment	0	0	0	0
Total	0	0	0	0

Sexual Abuse and Sexual Harassment Investigation Files Selected for Review

Sexual Abuse Investigation Files Selected for Review

98. Enter the total number of SEXUAL ABUSE investigation files reviewed/ sampled:	0

a. Explain why you were unable to review any sexual abuse investigation files:	The facility's Executive Director/PREA Coordinator reported to this auditor her error when completing the PAQ. She in error reported one sexual abuse on the PAQ but during the onsite visit, this auditor reviewed the files and ascertained that there were zero sexual abuse investigation files to review or any sexual investigations that had occurred in the last 12 months.
99. Did your selection of SEXUAL ABUSE investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	○ Yes ◉ No ○ NA (NA if you were unable to review any sexual abuse investigation files)
Inmate-on-inmate sexual abuse investigation files	
100. Enter the total number of INMATE-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	0
101. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	○ Yes ◉ No ○ NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
102. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	○ Yes ◉ No ○ NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
Staff-on-inmate sexual abuse investigation files	
103. Enter the total number of STAFF-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	0

104. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	○ Yes ◉ No ○ NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)
105. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	○ Yes ◉ No ○ NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)
Sexual Harassment Investigation Files Selected for Review	
106. Enter the total number of SEXUAL HARASSMENT investigation files reviewed/sampled:	0
a. Explain why you were unable to review any sexual harassment investigation files:	The facility reported on the PAQ that there were zero sexual harassment investigation that had occurred in the last 12 months. This auditor reviewed the files, which were none, and ascertained that there were zero sexual harassment investigation files to review or any sexual harassment investigations that had occurred in the last 12 months.
107. Did your selection of SEXUAL HARASSMENT investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	○ Yes ◉ No ○ NA (NA if you were unable to review any sexual harassment investigation files)
Inmate-on-inmate sexual harassment investigation files	
108. Enter the total number of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	0

109. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT files include criminal investigations?	○ Yes ◉ No ○ NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)
110. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	○ Yes ◉ No ○ NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)
Staff-on-inmate sexual harassment investigation files	
111. Enter the total number of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	0
112. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include criminal investigations?	○ Yes ◉ No ○ NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
113. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	○ Yes ◉ No ○ NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)

114. Provide any additional comments regarding selecting and reviewing sexual abuse and sexual harassment investigation files.	The facility reported on the PAQ that there were zero Staff-on-Inmate Sexual Harassment investigations the last 12 months. This auditor reviewed the investigation files, which were none, and ascertained that there were zero sexual abuse and sexual harassment investigation files to review or that had occurred in the last 12 months.

SUPPORT STAFF INFORMATION

DOJ-certified PREA Auditors Support Staff

115. Did you receive assistance from any DOJ-CERTIFIED PREA AUDITORS at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	○ Yes ◉ No

Non-certified Support Staff

116. Did you receive assistance from any NON-CERTIFIED SUPPORT STAFF at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	○ Yes ◉ No

AUDITING ARRANGEMENTS AND COMPENSATION

121. Who paid you to conduct this audit?	◉ The audited facility or its parent agency ○ My state/territory or county government employer (if you audit as part of a consortium or circular auditing arrangement, select this option) ○ A third-party auditing entity (e.g., accreditation body, consulting firm) ○ Other

Standards
Auditor Overall Determination Definitions
• Exceeds Standard (Substantially exceeds requirement of standard) • Meets Standard (substantial compliance; complies in all material ways with the stand for the relevant review period) • Does Not Meet Standard (requires corrective actions)
Auditor Discussion Instructions
Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.311	Zero tolerance of sexual abuse and sexual harassment; PREA coordinator
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.311 (a) SHHRTC has a zero-tolerance policy towards all forms of sexual abuse, and sexual harassment. The purpose of the policy "is to establish the SHHRTC's zero-tolerance policy for any form of sexual abuse, sexual harassment, or sexual activity involving resident in the agency's care. This rule also addresses SHHRTC's obligations under federal Prison Rape Elimination Act (PREA) standards for preventing, detecting, and responding to sexual abuse and sexual harassment." The SHHRTC Zero Tolerance Policy is available to staff, residents, and to members of the public by being posted on the agency's website at www.shamarhopehaven.org. Under the general provisions section of SHHRTC's PREA policy it outlines the agency's approach towards preventing, detecting, and responding to sexual abuse and sexual harassment. The facility is in compliance with this provision. 115.311 (b) The agency's Zero Tolerance policy states that "SHHRTC shall designate an upper-level staff member as the agency wide PREA Coordinator". The agency has a designated the Executive Director as the PREA Coordinator. She holds an upper

	level position and has stated during her interview that she has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in her facility. The facility is in compliance with this provision. 115.311 (c) The agency's Zero Tolerance policy states that "SHHRTC shall designate a PREA Compliance Manager at each SHHRTC operated residential facilities. This staff member's duties must be structured to allow sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards". During the interview with the Program Director, who has been designated as the PREA Compliance Manager, she stated that she has sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards. She also informed this auditor that since they have closed down and sold the Wheeler house in 2022, now only operate the Truxillo house, her role during this audit period has reverted back to being just the Program Director. This auditor decided to interview her utilizing the specialized staff protocol for the PREA Compliance Manager to gain her insight while she was in this position. The facility is in compliance with this provision. Corrective Action Findings: None This facility is in compliance with this standard.

115.312	**Contracting with other entities for the confinement of residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.312 (a) SHHRTC is not a public agency but is a non-profit, private agency run facility. SHHRTC stated on the PAQ that the agency has not entered into and or renewed a contract with any entity for the confinement of their residents. However, SHHRTC does contract with Dallas, Tarrant and Harrison counties Juvenile Probation Departments as well as with the Texas Department of Health Services Family and Protective Services (TXDFPS) to provide residential services for their residents. The agency's Executive Director/PREA Coordinator and Program Director confirmed during their interviews that the agency does not contract for the confinement of their residents with other entities but do contract with Dallas, Tarrant and Harrison counties Juvenile Probation Departments as well as with the Texas Department of Health Services Family and Protective Services (TXDFPS) to provide residential services for their residents. A review of the contracts with the three Juvenile Probation Departments (Dallas, Tarrant and Harrison counties), do state that SHHRTC will "comply with the Final Rule of the Prison Rape Elimination Act (PREA) of June 20, 2012 and with all applicable PREA standards". This was confirmed during the interview of the Agency Contract Administrator, which is the Executive Director/ PREA Coordinator. SHHRTC did provide this auditor with copies of the contracts with TXDFPS, Dallas, Tarrant and Harrison counties for his review during the pre-audit

	and onsite audit phase. This facility is in compliance with this provision. 115.312 (b) SHHRTC contracts with Dallas, Tarrant and Harrison counties as well as with the Texas Department of Health Services Family and Protective Services to provide residential services for their residents. These three county Juvenile Probation Departments also have a clause in their contracts, as reviewed by this auditor, for monitoring SHHRTC to ensure that they are in compliance with the PREA standards during the contract period. The contract with TXDFPS does not require SHHRTC to comply with the PREA standards because the youth placed in this facility comes from the community (child protective services) who have not been adjudicated in the criminal justice system. This facility is in compliance with this provision. Corrective Action Findings: None. This facility is in compliance with this standard.

115.313	**Supervision and monitoring**
	Auditor Overall Determination: Exceeds Standard
	Auditor Discussion
	115.313 (a) SHHRTC's Zero Tolerance Policy states that "SHHRTC shall develop and implement a written staffing plan to provide adequate levels of staffing or video monitoring (if applicable) to protect resident against sexual abuse." The PAQ reflected no instances of a deviation from the planned staff to resident ratio, which is 1 to 8 during waking hours and 1 to 16 during sleeping hours in accordance with the PREA standards. The facility's staff to resident operating ratio, which exceeds the PREA standards ratio, is 1 to 5 during waking hours and 1 to 12 during sleeping hours. SHHRTC is a non-secure residential facility, whose primary resident population are from the Texas Department of Family and Protective Services (TXDFPS) (child protective services) and by PREA definition, is not required to be PREA audited. The Executive Director/PREA Coordinator has elected to have SHHRTC PREA audited once again because of her desire to receive and provide services to juvenile justice youth from Dallas, Tarrant and Harrison County's Juvenile Probation Departments. With this being said, SHHRTC currently have all 8 or 100% of the TXDFPS youth in their population as of the onsite audit. SHHRTC's staffing plan was provided during the pre-audit phase and reviewed by this auditor. Based on the average resident population by month for the past 12 months, which is 8 and taking into consideration a low staff turnover rate in the past 12 months, this auditor found no obvious reason to believe there had been any deviation from the facility's staffing plan. TXDFPS contractual agreement requires that SHHRTC maintain a 1 to 5 and a 1 to 12 staff/resident ratio, which exceeds the PREA requirement of staff to resident ratio for this facility. SHHRTC does use surveillance cameras to aid the facility staff in monitoring the residents in Truxillo

	house. There are 5 cameras in and outside of this residential house: At the front entrance, in the dining rooms, in the common area, the group room and at the rear of the building. Through the staff interviews, this auditor found no reports of short staffing or ratio deviations in the daily monitoring and supervision of the residents. There were no findings of judicial inadequacy, inadequacies from a Federal investigative agency, or inadequacies from an internal or external oversight body (e.g. Dallas, Tarrant and Harrison County's Juvenile Probation or TXDFPS Regulatory agency). During the site review this auditor did not identified any blind spots or areas in the facility where staff or residents may be isolated. This staffing plan and video monitoring does take into account the composition of the population, which as of the onsite audit is 100% TXDFPS residents and 0% juvenile justice residents. The staffing plan also takes into consideration the following: · The number and placement of supervisory staff · Employees work shifts, · Applicable state, local laws, regulations and standards · Prevalence of substantiated and unsubstantiated incidents of sexual abuse · Other relevant factors Further evidence of compliance with this standard was ascertained during the interviews of the Executive Director/PREA Coordinator and the Program Director/ PREA Compliance Manager. Both these individuals confirmed that SHHRTC’s staffing plan was developed to ensure that adequate staffing is maintained in the facilities to protect the residents, and that the video monitoring is employed, as part of the staffing plan, to further detect, prevent and protect residents against sexual abuse. The facility is in compliance with this provision 115.313 (b) The SHHRTC Zero Tolerance Policy as well as their contracts with Dallas, Tarrant and Harrison County's Juvenile Probation Departments and TXDFPS requires constant supervision and monitoring of the residents while in the facilities. The policy states that the facility maintains a 1 to ratio during waking hours and a 1 to 16 staff ratio during sleeping hours except during limited or discrete exigent circumstances. Onsite observations by this auditor, during the audit, exceeded the established written ratios. Observed ratios were 1:5 during waking hours and 2:16 during sleeping hours. The Executive Director/PREA Coordinator stated during her interview that there have been no deviations from the ratio in the last 12 months. The facility is in compliance with this provision 115.313 (c) SHHRTC facility roster showed 19 full time staff employed of which 11 are direct care staff, 2 child care supervisors, 3 case managers, 1 Program Director, and 2 are administrative office staff along with 2 contractors. The resident roster provided during the pre-audit phase reflected their current population of 8 residents. This auditor found no evidence nor was there a report of the staff to resident ratio

deviating from the planned ratio of 1:5 during the daytime nor from 1 to 12 during sleeping hours, which exceeds the PREA Standard ratio of 1:8 during waking hours and 1:16 during sleeping hours. This ratio only include the direct care staff (security). SHHRTC did not document any deviations from the staffing ratio during any limited or discrete exigent circumstances. SHHRTC is a non-secure facility and calculating the ratios are not applicable and SHHRTC is obligated by TXDFPS regulations and contractual agreement to maintain a 1 to 5 ratio during the daytime and 1 to 12 ratio during sleeping hours. The facility currently does not have any juvenile justice residents in the facility. The facility is in compliance with this provision

115.313 (d) SHHRTC's Executive Director/PREA Coordinator and Program Director/ PREA Compliance Manager indicated during their interviews that they did confer in the last 12 months in the development of the staffing plan and discussed what adjustments were needed in the development of the staffing plan, which was provided to this auditor during the pre-audit phase. They indicated that they also considered the following in the development of the staffing plan:

· Prevailing staffing patterns

· Deployment of video monitoring systems and other technologies

· Available resources needed to adhere to the staffing plan

The facility is in compliance with this provision

115.313. (e) SHHRTC's Executive Director did indicate during her interview that the direct care staff's supervisor and the PREA Compliance Manager do conduct unannounced rounds to identify and deter staff sexual abuse and sexual harassment. During the interview with the Program Director/PREA Compliance Manager and the Intermediate Level Staff, they both indicated that they do conduct unannounced round in the facility at least twice a month on all three shifts, though this is a non-secure facility. The Unannounced Logs, which was provided to this auditor during the pre-audit phase, upon review, does reflect the dates, times and staff who conducted the unannounced rounds for the last 12 months thereby corroborating their interview statements. This auditor also found evidence on the PAQ reflecting that the higher-level staff do conduct unannounced rounds on all shifts though this is a non-secure residential facility .

SHHRTC's Zero Tolerance Policy does states that disciplinary action will occur if staff alert other staff of the unannounced rounds. During the random staff interviews the staff did explain the unannounced rounds do occur and that they are aware of the consequences if they alert other staff of the unannounced rounds. During the interview with the direct care staff supervisor, he indicated that staff are aware of the consequences of alerting other staff of an unannounced round and because of the configuration of the house, he can enter through the back door and or front door quietly to monitor the staff during the late night hours to ascertain if they are alert and performing their supervision responsibilities. SHHRTC Zero Tolerance policy states that it does prohibit the staff from alerting other staff of an unannounced

	round being made by an intermediate and or higher-level staff member. The facility is in compliance with this provision The facility is in compliance with this standard. Corrective Action Findings: None

115.315	Limits to cross-gender viewing and searches
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.315 (a): SHHRTC Zero Tolerance policy states that "SHHRTC will maintain restrictions and limitations on cross-gender searches and shall always refrain from conducting cross gender strip or cross gender visual body cavity searches, except in exigent circumstances or by a medical practitioner”. The Executive Director/PREA Coordinator also provide a copy of the facility's search policy to corroborate this assertion. This is an all-male facility and all staff, including female, have been trained on how to conduct a cross gender pat search and a copy of their training records on this topic was provided to this auditor for his review. The Executive Director/PREA Coordinator did provide a memorandum to corroborate this assertion. The random staff training files and interviews revealed that they were trained on how to conduct a cross gender pat down search. Two of the random female direct care staff interviewed stated that female staff do not conduct cross gender pat down searches on the male residents except in exigent circumstances. They gave an example of an exigent circumstance like a hurricane had destroyed parts of the facility and with only female direct staff working, they would have to remove the residents to another facility but must first ensure that it is safe to load them on the van amidst the glass, metal objects, etc. for safety reasons, whereas a pat search would have to occur. They further indicated that there has not been an exigent circumstance in the last 12 months to warrant such a cross gender pat down search. The facility is in compliance with this provision 115.315 (b): SHHRTC is an all-male facility and interviews conducted with all 11 the random staff, inclusive of the female direct care staff, revealed that the female staff have not conducted cross gender pat down searches in non-exigent circumstances in the last 12 months. This auditor was provided with a sampling of pat search logs conducted during this audit period and no cross gender pat searches were recorded. The facility is in compliance with this provision 115.315 (c): SHHRTC Zero Tolerance policy states “that they will maintain restrictions and limitations on cross-gender searches and shall always refrain from conducting cross gender strip or cross gender visual body cavity searches, except in exigent circumstances or by a medical practitioner”. SHHRTC Executive Director/

	PREA Coordinator stated during her interview that they do not conduct cross gender strip searches and cross gender visual body cavity searches in her facility, but if they did, she would ensure that these would be documented and justified in accordance to this provision. The facility is in compliance with this provision 115.315 (d): SHHRTC Zero Tolerance policy states that “staffing patterns and physical barriers are implemented to 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”. This is an all-male facility. The facility’s bathrooms are designed to prohibit cross gender viewing of resident performing such personal actions because of having locking doors to avoid staff or other residents from viewing them in both locations. The facility schematic shows the resident's bathroom/shower areas location in Truxillo house are located on the 2nd floor between the bedrooms. This auditor confirmed the schematic plans of these areas during the site review. SHHRTC requires staff of the opposite gender to announce their presence when entering the residential housing and before going upstairs to the bedroom and bathroom areas in the house. During the interviews with the all 11 of the random staff they confirmed that the female staff do make an announcement saying: Female staff is coming upstairs, before they proceed to the bedroom areas. The random male staff further stated that they do not allow the female staff to come upstairs during shower and restroom routines of the residents. This statement was also confirmed during the random resident interviews. 8 out of 8 random residents interviewed stated that the female staff do not allowed upstairs during shower, restroom routines and that they do announce their presence before coming upstairs to the bedroom areas of the residents. This auditor did observe a female staff announce her presence when seeking to go upstairs to the bedroom area of the residents in Truxillo house even though there was a male staff upstairs. The female staff did make the announcement "female staff coming upstairs", thereby notifying the residents of her presence. The facility is in compliance with this provision 115.315 (e) SHHRTC Zero Tolerance Policy states that “staff do not search or physically examining transgender or intersex residents for the sole purpose of determining the resident’s genital status. The status may be determined during conversations with the resident, by reviewing medical records, or as part of a broader medical examination conducted in private by a medical practitioner”. The Executive Director/PREA Coordinator stated during her interview that this policy is adhered to by her staff and that there have been no transgender or intersex residents in her population in the last 12 months. A review of the residents file revealed that there have been no transgender or intersex residents admitted into this facility in the last 12 months. The facility is in compliance with this provision 115.315 (f) SHHRTC did provide evidence that all of the direct care staff have been train on 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 including how to conduct searches of transgender and intersex residents in a professional and respectful manner. A review of the employees training records revealed that all staff have received cross gender pat search training, searches of transgender and intersex residents followed by an acknowledgement statement and signature on the training roster. This is an all-male facility. SHHRTC reported on the PAQ that they have not had any transgender or Intersex residents in their population in the last 12 months. The facility is in compliance with this provision This facility is in compliance with this standard. Corrective Action: None

115.316	**Residents with disabilities and residents who are limited English proficient**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.316 (a) The SHHRTC Zero Tolerance Policy states that “SHHRTC will take reasonable steps to ensure meaningful access to all aspects of the agency’s efforts prevent, detect, and respond to sexual abuse and sexual harassment residents who are: · Deaf or hard of hearing · Blind or have low vision · Limited English Proficient and reading skills · Intellectually disabled · Psychiatric disabled · Speech disability And that appropriate steps will be taken to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency’s effort to prevent, detect, and respond to sexual abuse and sexual harassment. SHHRTC has taken steps to ensure that there is effective communication with residents who are: Deaf or hard of hearing · Blind or have low vision

	· Limited English Proficient and reading skills · Intellectually disabled · Psychiatric disabled · Speech disability By entering into an agreement with the Houston Independent School District (HISD) to provide these services to the residents in their facility. SHHRTC also has access to the language line, when needed, for residents requiring interpreting in another language. The Executive Director/PREA Coordinator indicated during her interview that HISD will and does provide these services to SHHRTC residents as needed since these residents are enrolled in HISD school. She did provide a copy of the Memorandum of Understanding from HISD to affirm that HISD would provide these services as of the onsite visit. This facility is in compliance with this provision. 115.316. (b)SHHRTC Zero Tolerance policy states that they will " 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 in English proficient, including steps to provide an interpreter who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary". SHHRTC Program Director/PREA Compliance Manager did indicate during her interview that they will do whatever is necessary to ensure the residents understand the PREA standards and their rights. They will utilize, when necessary, staff as translators, the contracting Interpreter, the language line, and HISD's special education resources for residents who may be deaf, speech impaired, limited in English proficiency and reading skills, blind and or low vision or who are psychiatric or are intellectually impaired. At the time of the audit, nor in the past 12 months, did the facility have any resident who were assessed as needing interpreting services, had a disability or were limited English proficient. This determination was made based on interviews of the Intake staff, program staff, and a review of the resident files. This facility is in compliance with this provision. 115.316 (c) SHHRTC Zero Tolerance policy states that SHHRTC does not use or rely on other residents to interpret, read, or otherwise assist except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise safety, the performance of first responder duties, or an investigation". The Executive Director/PREA Coordinator and Intake staff stated during their interviews that SHHRTC does not use resident interpreters or assistants for reporting sexual abuse and sexual harassment allegations in the last 12 months. During the random staff interviews all 11 of the staff indicated that SHHRTC has not utilized resident interpreters or assistants for reporting sexual abuse and sexual harassment allegations. SHHRTC does have a contractual agreement with an Interpreter to provide interpreting services when needed. During the interview with the Interpreter, she indicated that in the last 12 months she has not had to provide any interpreting services to any resident in this facility. This facility is in compliance with this provision.

	This facility is in compliance with this standard. Corrective Action: None

115.317	Hiring and promotion decisions
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.317 (a). SHHRTC Zero Tolerance policy states that “SHHRTC does not hire or promote anyone who may have contact with resident and does not use services of any contractor who may have contact with the person if the person: (I) 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; (ii) who have 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, of if the victim did not consent or was unable to consent or refuse. (iii) Enlist the services of any contractor who has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution; or who have 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, of if the victim did not consent or was unable to consent or refuse. The Human Resource staff confirmed during his interview that SHHRTC has not hired, promoted, or contracted with anyone who meets the criteria listed above in (I) through (iii). A review of employee files revealed that there was no documented evidence of SHHRTC hiring, promoting or utilizing the services of any contractors during the last 12 months as stated above. The facility is in compliance with this provision 115.317 (b) SHHRTC Zero Tolerance Policy states that “For any person who may have contact with juveniles, SHHRTC will consider any incidents of sexual harassment in determining whether to hire, promote, or contract for services”. The Human Resource staff indicated during his interview that a thorough criminal background check, pre-employment reference checks, and a child abuse registry checks are conducted before an applicant or contractor is offered a position and that criminal background checks are conducted at least every five (5) years on all employees. He further stated that a “hit” would automatically come to him via email from the Department of Public Safety (DPS) if any of his current employees are arrested or come in contact with law enforcement. A review of the employee and contractor files revealed no documented evidence of SHHRTC hiring, promoting or procuring the services of a contractor in violation of this provision. The facility is in

	compliance with this provision 115.317 (c) SHHRTC Zero Tolerance Policy states that “before hiring new employees who may have contact with resident, SHHRTC Executive Director will: (i) Performs a criminal background records check (ii) Consults the child abuse registry maintained by Texas Department of Family and Protective Services (DFPS); and (iii) Consistent with Federal, State and local laws makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. A review of the employee files revealed that SHHRTC have been conducting background checks and completing reference checks were being ask of any potential employee regarding substantiated allegations of sexual abuse or resignation during a pending investigation of an allegation of sexual abuse. During the interview with the Human Resource staff he stated that none of the last 12 news hires came from an institutional employer. During the employee file review, it was ascertained that no institutional reference check were performed on these 12 new hires since they did not come from an institutional employer. During the onsite audit this auditor was provided with a sample letter that would be sent to a prior institutional employer for information on substantiated related incidents and resignations. Further review of the employee files revealed that documented child abuse registry checks through the Department of Health Services (DHS) have been conducted on all employees in the last 12 months. The facility is in compliance with this provision 115.317 (d) SHHRTC Zero Tolerance Policy states that “before enlisting the services of a contractor who may have contact with residents, the Executive Director will: (i) Performs a criminal background records check (ii) Consults the child abuse registry maintained by Texas Department of Family and Protective Services (DFPS); Further review of the contractor file revealed that documented child abuse registry checks through the Department of Health Services (DHS) had been conducted in the last 12 months. The facility is in compliance with this provision 115.317 (e) SHHRTC does conduct criminal background checks every five years of current employees and on contractors who may have contact with residents. This was evidenced through the employee file review of the staff and contractor and confirmed during the interviews with the Executive Director and Human Resource staff. Copies of the criminal background checks conducted on the employees during this auditing period were provided to this auditor during the onsite visit. The facility is in compliance with this provision

	115.317 (f) SHHRTC Zero Tolerance Policy states that they will ”ask applicants and employees who may have contact with youth directly about previous misconduct described in subparagraph (A) of this paragraph in written applications or interviews for hiring or promotion and in any interviews or written self-evaluations conducted as part of reviews of current employees. SHHRTC employees have a continuing affirmative duty to disclose any such misconduct. Material omissions regarding such misconduct or the provision of materially false information is grounds for termination of employment”. SHHRTC did provide to this auditor during the pre-audit phase completed “PREA Self-Disclosure” documents on each employee as part of their continuing affirmative duty to disclose any such misconduct. The facility is in compliance with this provision 115.317 (g) SHHRTC Zero Tolerance Policy states that they” material omissions regarding such misconduct or the provision of materially false information is grounds for termination of employment”. The Human Resource staff did indicate during his interview that all staff and contractors have been informed of this policy and that there have been no violations of this policy in the last 12 months. The facility is in compliance with this provision 115.317 (h) SHHRTC Zero Tolerance Policy “that unless prohibited by law, SHHRTC provides information on substantiated allegations of sexual abuse or sexual harassment involving former employees upon receiving a request from an institutional employer for whom the former employee has applied to work”. During the interview with the Human Resource staff, he indicated that such disclosure would not be an issue because most reference checks are accompanied by written permission to disclose information from the subject of the reference check. At the time of the onsite audit the SHHRTC Human Resource staff indicated that he had not received any requests for information from a juvenile institution on a current staff. He also indicated that he has not requested information on any of the 12 new hires in 2023. During an interview with the new hire random staff they corroborated that they have not been previously employed an institutional employer. Upon review of these 12 employee files it was ascertained that no institutional reference check letter was in their file confirming their admission. The facility is in compliance with this provision. This facility is in compliance with this standard. Corrective Action: None

115.318	**Upgrades to facilities and technologies**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.318 (a) SHHRTC Zero Tolerance Policy states that “When designing or acquiring any new facility and in planning any substantial expansion or modification of

	existing facilities, SHHRTC will consider the effect of the design, acquisition, expansion, or modification on the agency's ability to protect residents from sexual abuse". The Executive Director/PREA Coordinator and the Program Director/PREA Compliance Manager indicated during their interviews that there have not been any expansion or modification of existing facilities to consider the effect of the design, acquisition, expansion, or modification upon SHHRTC's ability to protect residents from sexual abuse. The facility is in compliance with this provision 115.318 (b) SHHRTC Zero Tolerance Policy states that "When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, SHHRTC considers how such technology may enhance the agency's ability to protect youth from sexual abuse". During the site review this auditor notices that SHHRTC has installed 5 cameras in the Truxillo House to enhance the agency's ability to protect residents from sexual abuse. One in the entrance, one in the dining room, one in the group room, one in the common area and one at the rear of the building. Four cameras have been installed in the Administrative building, one at the entrance, one in the lobby/waiting area, one in the Executive Director's office and one at the rear of the building. No other cameras or electronic surveillance systems have been installed since the last audit nor in the last 12 months. The facility is in compliance with this provision. The facility is in compliance with this standard. corrective Action: None

115.321	**Evidence protocol and forensic medical examinations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.321 (a) SHHRTC is not responsible for investigating allegations of sexual abuse and sexual harassment. The Harris County Sheriff Department conducts the criminal investigations and the Texas Department of Family and Protective Services Licensing Division conducts the administrative investigations. These entities are responsible for following the uniform evidence protocol that maximizes the potential of obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The facility is in compliance with this provision 115.321 (b) SHHRTC is not responsible for investigating allegations of sexual abuse and sexual harassment. The Executive Director/PREA Coordinator indicated during her interview that the Harris County Sheriff Department and the Texas Department of Family and Protective Service (TXDFPS) would utilize the US Department of Justice's Office of Violence Against Women publication, A National Protocol for Sexual Assault Medical Forensic Examination, Adults/Adolescents that has been developed after 2011 when conducting an investigation. She did provide this auditor with a copy of the protocol and stated that both entities are aware of and will utilize

	this protocol. The facility is in compliance with this provision 115.321 (c) SHHRTC Zero Tolerance Policy states that “when evidentiarily or medically appropriate, SHHRTC transports residents who experience sexual abuse to a hospital , clinic or emergency room that can provide for medical examination by a Sexual Assault Nurse Examiner (SANE) at the Texas Children's Hospital, and that such medical examinations are provided at no financial cost to the resident”. The facility is in compliance with this provision The Executive Director/PREA Coordinator stated during her interview that in the event of a sexual abuse allegation, SHHRTC would call the Harris County Sheriff Department for criminal investigations and they would take the resident to Texas Children’s Hospital for the forensic examination as applicable. During the interview with a representative from the Texas Children's Hospital 's SANE Nurse department, they referred this auditor to the hospital web site where under the “Forensic Medicine” tab the following mission statement was found: “The Child Protective Heath Care Team at Texas Children’s Hospital provides compassionate, sensitive, timely care for victims of violent crimes, child abuse and neglect.” The SANE Nurse representative explained that she was the lead SANE nurse, but in her absence another forensic nurse would be on duty. She explained it was hospital practice to have a forensic nurse available 24 hours a day. The hospital web site explains, “when sexual assault has occurred, a forensic nurse who is a sexual assault nurse examiner (SANE) will provide nonjudgmental, compassionate care to the patient. SANEs are registered nurses who have had specialized training in the comprehensive medical forensic care of patients who have experienced sexual assault. They are certified by the Texas Office of the Attorney General.” The Executive Director/PREA Coordinator further indicated during her interview that there have been no referrals of a resident sexual abuse victim to the Texas Children’s Hospital in the last 12 months. A review of the resident files corroborated this assertion. The facility is in compliance with this provision 115.321 (d) SHHRTC Zero Tolerance Policy states that SHHRTC will seek to secure victim advocacy services from a local rape crisis center”. Rape Crises Center services are provided free of charge by the Sexual Assault Resource Center (SARC) a community-based organization that provide emotional support, counseling and advocacy services. The Executive Director/PREA Coordinator did provide a Memorandum of Understanding between SHHRTC and the SARC in an attempt to continue procuring the services to be offered, in the event that they have a resident sexual abuse victim and abuser. According to the SARC representative, once a sexual abuse victim (resident) is referred to the Texas Children’s Hospital they will receive “wraparound” services e.g. SANE examination, victim advocacy, emotional support and counseling service through this established consortium network. The Program Director/PREA Compliance Manager indicated during her interview that a victim advocate is always made available to victims of sexual abuse SARC. She further indicated that there have been no referrals of sexual abuse victims to the Texas Children’s Hospital in

	the last 12 months. A review of the resident files corroborated this assertion. The facility is in compliance with this provision 115.321 (e) SHHRTC Executive Director/PREA Coordinator indicated during her interview that if a sexual abuse victim requests, a qualified staff member would accompany the resident through the forensic medical examination process and investigatory interviews. The Program Director/PREA Compliance Manager is a qualified mental health counselor on duty 5 days a week to provide advocacy, crisis intervention counseling and emotional support services when applicable, in conjunction with the SARC. However, the Texas Children's Hospital services through the SARC remains available 24/7 to support victims through the forensic medical examination process and investigatory interview process also. These services include the forensic examination, emotional support, crises intervention, information, and referrals. During the phone interview with the SANE Nurse representative at the Texas Children's Hospital, she confirmed that she is qualified to conduct Sexual Assault Medical Forensic Examinations (SANE) for obtaining usable evidence for administrative or criminal investigations. The facility is in compliance with this provision 115.321 (f) SHHRTC Executive Director/PREA Coordinator did provide this auditor with a copy of the Memorandum of Understanding sent to the Harris County Sheriff Department indicating that they will conduct all criminal sexual abuse investigations in this facility. As of this report a signed copy of that memorandum of understanding has not been returned to the facility. During the file review it was ascertained that the Harris County Sheriff Department have not conducted any sexual abuse investigations in this facility in the last 12 months. The facility is in compliance with this provision 1155.321 (g) SHHRTC Executive Director did state during her interview that the requirements of paragraph (a) through (f) of this provision will apply to the Texas Department of Family and protective Services Licensing Division who would conduct administrative investigations in the facility. She further stated that there is no Department of Justice component responsible for conducting investigations in this facility. The facility is in compliance with this provision. 115.321. (h) The Executive Director/PREA Coordinator and the Program Director/ PREA Compliance Manager both stated during their interviews that SHHRTC would always make a victim advocate from the SARC available to victims, though they have not needed to utilize these services for their resident. They further stated that the PREA Compliance Manager and the advocate in the community have been screened for appropriateness to serve in this role and has received education concerning sexual assault and forensic examination issues in general. In the last 12 months there was no documented evidence that a resident victim had been referred to SARC for any victim advocacy services. The facility is in compliance with this provision This facility is in compliance with this standard. Corrective Action Findings: None

115.322	Policies to ensure referrals of allegations for investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.322 (a) The SHHRTC Zero Tolerance Policy states that “that all allegations of sexual abuse and sexual harassment that are reported will be investigated by and completed by the Texas Department of Family and Protective Services (TXDFPS) Licensing Division for administrative investigations and by the Harris County Sheriff Department for criminal investigations”. During the file review it was ascertained that there were zero reported administrative sexual abuse and sexual harassment investigations conducted during the past 12 months. It was also ascertained that there were zero criminal sexual abuse investigations conducted in the last 12 months. The facility is in compliance with this provision. 115.322 (b) SHHRTC Zero Tolerance Policy states that “all allegations of sexual abuse and sexual harassment are assigned to the appropriate agency, Texas Department of Family and Protective Service (TXDFPS) Licensing Division for administrative investigations and to the Harris County Sheriff Department for criminal investigation”. The Zero Tolerance Policy is in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an appropriate agency with the legal authority to conduct criminal investigations. Currently, this policy is made available in the administrative office of SHHRTC in the lobby area upon request and on the agency's website at www.shamarhopehaven.org. The Executive Director/ PREA Coordinator and the Program Director both indicated during their interviews that there have been zero administrative sexual abuse, sexual harassment investigations conducted by TXDFPS and zero criminal sexual abuse investigations conducted by the Harris County Sheriff Department in the last 12 months. This admission was also corroborated during the file review conducted by this auditor. The facility is in compliance with this provision. 115.322 (c) SHHRTC Zero Tolerance Policy states that “all allegations of sexual abuse and sexual harassment are assigned to the appropriate agency, Texas Department of Family and Protective Service (TXDFPS) Licensing Division for administrative investigations and to the Harris County Sheriff Department for criminal investigation”. The facility's Zero Tolerance policy is posted on the agency's website at www.shamarhopehaven.org that reflects the agencies responsible for conducting the administrative and criminal sexual abuse investigations. The facility is in compliance with this provision. 115.322 (d) The Department of Family and Protective Services (DFPS) is the State entity that is responsible for conducting any administrative sexual abuse and sexual harassment investigations in this facility. When this facility houses juvenile justice youth, then the Texas Juvenile Justice Department's Office of the Inspector General Office (TJJD OIG) is the other State entity that would conduct any administrative and criminal sexual abuse investigations. SHHRTC's Zero Tolerance policy is posted on

	the agency's website that governs the conduct of these entities investigations when applicable. A review of the resident files and a corroborated statement from the Executive Director during her interview revealed that this facility has not housed any juvenile justice residents in this facility since 2021 due to the Covid-19 pandemic. The facility is in compliance with this provision. 115.322 (e) The Executive Director/PREA Coordinator indicated during her interview that there is no Department of Justice component responsible for conducting any administrative and or criminal investigation in this facility. This is a private, non-profit residential treatment facility that do no house juvenile federal residents. The facility is in compliance with this provision. This facility is in compliance with this standard. Corrective Action Findings: None

115.331	**Employee training**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.331 (a) The SHHRTC Zero Tolerance Policy states that it will provide PREA related training to all its employees who may have contact with residents. SHHRTC training addresses: · How to fulfill their PREA responsibilities under SHHRTC policies and procedures. · Residents right to be free from sexual abuse and sexual harassment. · The right of residents and employees to be free from sexual abuse and harassment. · The right of residents to be free from retaliation for reporting sexual abuse and harassment · The dynamics of sexual abuse and sexual harassment in juvenile facilities. · The common reactions of juvenile victims of sexual abuse and harassment. · How to detect and respond to signs of threatened and actual sexual abuse. · How to avoid inappropriate relationships with residents. · How to communicate effectively and professionally with residents including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents. · How to comply with relevant laws related to mandatory reporting of sexual

	abuse to outside authorities. · Relevant laws regarding the applicable age of consent. It was ascertained during the interviews conducted with the 11 random staff that the PREA training they received does cover the above 11 points as required in this provision. SHHRTC Executive Director PREA Coordinator stated that they do utilize the 8-hour PREA Employee Training from the PREA Resource Center of the Moss Group and did provide this auditor with a copy of the curriculum. The facility is in compliance with this provision. 115.331 (b) The Executive Director/PREA Coordinator and the Compliance Manager states that the PREA training is tailored to the unique needs and attributes a gender of the residents at the facility. This is also corroborated from the PAQ response. SHHRTC is a single gender (all-male) facility and the staff of the opposite gender receive the same training regardless of where they are assigned. PREA training is provided during the new employee orientation training, as a refresher training every two years and during the annual training every 3 years. The training documentation reviewed and received by this auditor supports SHHRTC compliance with this standard. The facility is in compliance with this provision. 115.331 (c) SHHRTC Program Director/PREA Compliance Manager did provide to this auditor during the pre-audit phase written verification all of the staff received the annual in classroom PREA training June of 2023 and they all signed an acknowledgement statement indicating that they understood their PREA responsibilities. The Executive Director/PREA Coordinator indicated during her interview that all staff receives the refresher PREA training at the two year mark and annually. She further stated that each staff receives training on the Zero Tolerance policy annual as a refresher also. A signed acknowledgement form of the Zero Tolerance training was observed when reviewing the employee training and human resources files. The facility is in compliance with this provision. 115.331 (d) The SHHRTC Executive Director/PREA Coordinator did provide to this auditor during the onsite visit the training documentation where the staff acknowledged the training with their signature and that they understood the training they received. During the interviews with all of the staff it was ascertained that they had a good understanding of 115.331 (a, 1-11) and 115.331 (b), and 115.331 (c) thereby corroborating their signed acknowledgement statement. The facility is in compliance with this provision. This facility is in compliance with this standard. Corrective Action Findings: None

115.332	**Volunteer and contractor training**
	Auditor Overall Determination: Meets Standard

	Auditor Discussion
	115.332 (a) The SHHRTC Zero Tolerance Policy states that “SHHRTC ensures and documents all volunteers and contractors who have direct access to resident have been trained on and understand their responsibilities under PREA and any other SHHRTC policies and procedures”. There were no volunteers employed in the last 12 months therefore there were no volunteer files to review during the onsite audit phase. The Executive Director indicated on the PAQ that there was 1 volunteer hired in the last 12 months but in fact there are none. She further stated that this was made in error when completing the PAQ. A review of the contractors file revealed that there were 2 contractors that had been trained on their responsibilities under the agency’s Zero Tolerance policy in the last 12 months and zero volunteers were training in the last 12 months. She further indicated that the PAQ reflected 5 contractors when in fact there are only 2 contractors employed in the last 12 months. This too was made in error when completing the PAQ. The facility is in compliance with this provision. 115.332 (b) The SHHRTC Program Director/ PREA Coordinator did not provide documentation of any volunteer's acknowledgement of their PREA responsibilities and training necessary for compliance with this provision because there were none employed in the last 12 months. She did indicate that if there were any volunteers that they would receive the PREA training as required by this standard based on the services and level of contact they have with the residents. SHHRTC Executive Director/PREA Coordinator stated during her interview that the PREA training received by the contractors who have contact with the residents was on the agency's zero tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents. During the interview with the two contractors they stated that they did receive PREA training on how to report a sexual abuse and sexual harassment incident and on the agency's zero tolerance policy. The Executive Director/PREA Coordinator did provide a memorandum to corroborate this assertion. The facility is in compliance with this provision. 115.332 (c) A review of the contractors files revealed that SHHRTC does maintain documentation confirming that the contractors have understood the training that they received. During gthe interview with the two contractors, they both stated that they understood the PREA training received regarding the agency's zero tolerance policy and in the reporting of a sexual abuse and sexual harassment incident. They further state that they are mandatory reporters by law of such because of their occupation. This facility is in compliance with this provision. The facility is in compliance with this standard. Corrective Action Findings: None

115.333	**Resident education**
	Auditor Overall Determination: Meets Standard

	Auditor Discussion
	115.333 (a) The SHHRTC Zero Tolerance Policy states that “during the admissions/ intake process the resident are provided, by SHHRTC, age appropriate PREA information about the agencies Zero Tolerance Policy and how to report incidents or suspicions of sexual abuse, sexual harassment or sexual activity”. The Program Director/PREA Compliance Manager indicated during her interview that this is done through verbal explanation by the intake staff after being provided the appropriate PREA education information in the PREA brochure and in the Resident Handbook. The Intake staff corroborated this statement during her interview. The Safeguarding Your Sexual Safety video does address the following points: · Resident rights to be free from sexual abuse and sexual harassment · Their rights to be free from retaliation for reporting such incidents · The agency’s policies and procedures for responding to such incidents. The SHHRTC Program Director/PREA Compliance Manager did provide this auditor with the SHHRTC Resident Handbook in English and Spanish and a copy of the Safeguarding Your Sexual Safety video that is shown to the residents for his review. During the random resident interviews, 8 of 8 residents reported that this information was provided and explained to them upon intake. They further indicated that they understand the zero-tolerance policy and know how to report a sexual abuse and sexual harassment allegation. Over the past twelve months 35 residents were admitted to SHHRTC and all of the intake packets included an acknowledgement signed by each resident that they received the PREA education and understood the zero-tolerance policy information. When reviewing resident files this auditor found no evidence that there were residents who did not receive the required Zero Tolerance Policy information or the comprehensive education. The facility is in compliance with this provision. 115.333 (b) The SHHRTC Zero Tolerance Policy states that “within 10 days after admission, SHHRTC provides comprehensive, age appropriate education to resident about their rights to be free from sexual abuse, sexual harassment, and retaliation for reporting”. Through the random resident interviews this auditor found evidence that 8 of 8 residents had viewed the Safeguarding Your Sexual Safety PREA Video within 24 hours of their intake. This video is presented in an age-appropriate fashion about how to report a sexual abuse and sexual harassment allegation. This auditor did receive a copy of the video as proof of the actual PREA education is being provided to residents. Upon review of the video, it does inform the youth of: · Their rights to be free from retaliation for reporting such incidents · The agency’s policies and procedures for responding to such incidents. The facility is in compliance with this provision. 115.333 (c) During the random resident interviews 8 of 8 residents interviewed

	indicated that they had received the information on the agency's Zero Tolerance policy on the day of intake or the following day. A review of the resident files indicated that all 8 residents acknowledged that they did receive the comprehensive education within 10 days from the date of their intake. The signed acknowledgement statement for each resident further corroborated that they received this comprehensive education within 10 days after their intake. During the intake staff interview this auditor asked how they ensured current residents as well as those transferred from other facilities were educated on the agency's Zero Tolerance Policy. She stated that regardless of how, when, or where a resident comes to the facility, they are provided with the same comprehensive education about their rights to be free from sexual abuse, sexual harassment, retaliation and how to report a sexual abuse and sexual harassment allegation. During the interviews with the 8 residents they all indicated that they received comprehensive education on their rights, how to report a sexual abuse allegation and if they were being retaliated against within 3 days of being in the facility. They further indicated that occasionally topics on PREA is discussed each week during their group sessions. The facility is in compliance with this provision. 115.333 (d) The SHHRTC intake staff provided this auditor with the resident education in formats accessible to all residents at the facility during this audit, including materials translated into Spanish. This auditor was able to review a documented Memorandum of Agreement between SHHRTC and the Harris County Independent School District (HISD) regarding the provision of providing resident education for resident who are: · Limited in English Proficient · Visually impaired · Otherwise disabled · Having limited reading skills The Executive Director/PREA Coordinator indicated during her interview that HISD would provide assistance to them in creating education materials in formats accessible for residents that are deaf, visually impaired, have limited reading skills, otherwise disabled or have limited reading skills. When intake staff were asked how residents with limited reading skills could benefit from the PREA related information, she responded that the staff would read the printed information to the resident with the limited reading skills, have the resident watch the video, stop and explain the video and show the resident how they can call the 1 800 hotline number to report a sexual abuse and sexual harassment allegation. The facility is in compliance with this provision. 115.333 (e) The SHHRTC Program Director/ PREA Compliance Manager did provide to this auditor copies of the resident training rosters of the comprehensive education received and the signed acknowledgement statements of all 8 residents that they received and understood the PREA information. The facility is in

	compliance with this provision. 115.333 (f) During the site review of the SHHRTC this auditor did observe PREA and hotline posters in the residential house. These posters did include the 1-800 phone number for reporting a sexual abuse and sexual harassment allegation as well as the name and phone number for seeking emotional support and crisis intervention from the local rape crisis and or advocacy agency. This auditor also received a copy of and reviewed the PREA information that is in the resident handbook which is provided to the residents at intake. PREA brochures and Zero Tolerance flyers were observed during the site review in the lobby of the administration building, in the common areas, group room, and the dining area of the Truxillo house. The facility is in compliance with this provision. This facility is in compliance with this standard. Corrective Action Findings: None

115.334	**Specialized training: Investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.334 (a) SHHRTC Zero Tolerance Policy states that “SHHRTC staff member are not qualified to investigate allegations of sexual abuse and sexual harassment”. The Executive Director/PREA Coordinator indicated during her interview that no one on her staff is qualified to conduct sexual abuse and sexual harassment investigations and that by indicating such on the PAQ was in error.. These allegations are referred to either the Harris County Sheriff Department (HCSD) for criminal investigations or to the Texas Department of Family and Protective Services (TXDFPS) Licensing Division for Administrative investigations. This facility's staff do not conduct any administrative or criminal sexual abuse investigations. The facility is in compliance with this provision. 115.334 (b) Because administrative and criminal investigations are the responsibility of Harris County Sheriff Department and Texas Department of Family and Protective Services (TXDFPS), SHHRTC staff are not required, but these entities staff are required to have specialized training including techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. The facility is in compliance with this provision. 115.334 (c) SHHRTC Executive Director/PREA Coordinator stated during her interview that Harris County Sheriff Department and Texas Department of Family and Protective Services Licensing Division (TXDFPS) investigative personnel have received the required specialized training in accordance with these PREA standards

	for conducting sexual abuse investigations. The facility is in compliance with this provision. 115.334 (d) The Executive Director/PREA Coordinator stated during her interview that the Texas Department of Family and Protective Services (TXDFPS) is the State entity that would conduct administrative sexual abuse investigations in this facility and SHHRTC and that she has been assured that their investigative personnel have received the required specialized training in accordance with these PREA standards for conducting sexual abuse investigations. The facility is in compliance with this provision. This facility is in compliance with this standard. Corrective Action Findings: None

115.335	**Specialized training: Medical and mental health care**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.335 (a) The SHHRTC Zero Tolerance Policy states that SHHRTC ensures and maintains documentation that all full and part-time medical and mental health practitioners who work in SHHRTC operated facilities have been trained in how to: 1. How to detect and assess sins of sexual abuse and sexual harassment. 2. How to preserve physical evidence of sexual abuse. 3. How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment. 4. How and to whom to report allegations of sexual abuse and harassment. SHHRTC does not have any full or part time medical practitioners employed at the agency. Upon review of the training file it reflected that the Psychotherapist, who is a contractor, has received specialized training from the National Institute of Corrections (NIC) training portal for Behavioral Health Practitioners that addresses the following training 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 juvenile sexual abuse victims of sexual abuse and sexual harassment. · How and to whom to report allegations or suspicion of sexual abuse and sexual harassment.

	The Executive Director/PREA Coordinator also indicated that he has also received the basic in classroom 8-hour PREA training that the direct care staff received in the last 12 months. During the interview with this contractor he indicated that he has received training in PREA and on the agency's zero tolerance policy. The facility is in compliance with this provision. 115.335 (b) SHHRTC Human Resource staff indicated that they do not employ any medical staff who has received training in conducting forensic examinations and that these services would be made available to a resident victim at the Texas Children's Hospital where the forensic examinations would occur. He further stated that no SHHRTC staff has or is required to receive training related to forensic exams. The facility is in compliance with this provision. 115.335 (c) SHHRTC Human Resource staff did provide to this auditor documentation of the PREA training received by the contracting Psychotherapist within the last 12 months, which is maintained in his training records. This facility is in compliance with this provision. 115.335 (d) SHHRTC Human Resource staff did provide to this auditor documentation of the PREA training received by the contracting Psychotherapist as mandated for employees by 115.332. The facility is in compliance with this provision The facility is in compliance with this provision. Corrective Action Findings None

115.341	**Obtaining information from residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.341 (a) The SHHRTC Zero Tolerance Policy states that “SHHRTC does use an objective screening instrument within 72 hours after a resident’s admission to SHHRTC to obtain information about the resident’s personal history and behavior to reduce the risk of sexual abuse by or upon another resident”. Upon file review of the residents file, this auditor selected all 8 resident files and found that 100% of these files had a risk screening completed within the 72-hour time period. Upon further review it was ascertained that SHHRTC does periodically obtain information throughout a resident’s stay in this facility. This facility is in compliance with this provision. 115.341 (b) SHHRTC Zero Tolerance Policy states that “such an assessment shall be conducted using an objective screening tool". Upon review of the screening utilized by SHHRTC, it was ascertained that this tool is utilized for each resident that is admitted into the facility. The Intake staff indicated during her interview that

	residents are assessed with this periodic screening assessment tool during their stay to assess their risk levels, housing and supervision assignments. The facility is in compliance with this provision. 115.341 (c) The screening instruments used at SHHRTC, as reviewed by this auditor while onsite, does not attempt to ascertain the following information: 1. Prior sexual victimization or abusiveness; 2. Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore vulnerable to sexual abuse; 3. Current charges and offense history; 4. Age; 5. Level of emotional and cognitive development; 6. Physical size and stature; 7. Mental illness or mental disabilities; 8. Intellectual or developmental disabilities; 9. Physical disabilities; 10. The residents own perception of vulnerability; and 11. Any specific information about individual residents that may indicate heightened need for supervision, additional safety precautions, or separation from certain residents. The facility is in compliance with this provision. 115.341 (d) This auditor ascertained through the resident file audit and during the Intake staff interview that the risk assessments are being conducted through conversation with the resident during the intake, classification process; from the mental health screenings and from reviewing court records and other relevant documentation. Documentation of the intake screening were provided to this auditor. This facility is in compliance with this provision. 115l341 (e) The Executive Director/PREA Coordinator and Intake staff indicated during interviews that the information obtained during the initial and follow up screening is sensitive and is treated as confidential, therefore the information has limited dissemination and access to prevent exploitation. This information is controlled by double locking the paper files in a file cabinet of the secretary’s office, electronic files are password protecting the electronic records and only authorized employees are permitted to view the protected information on a need to know basis. During the site review this auditor was able to review these files in the secretary’s office, where they were stored. The facility is in compliance with this

	provision. The facility is in compliance with this standard Corrective Action Findings: None

115.342	Placement of residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.342 (a) SHHRTC's Zero Tolerance Policy states that SHHRTC will use all information obtained pursuant to 115.341 and subsequently, during intake screening to make housing, bed, program, education, and work assignments for resident. The Intake staff as well as the Executive Director/PREA Coordinator confirmed in their interviews that information learned during the intake screening is used to make informed housing assignments. Furthermore, the housing assignments are discussed anytime there is an incident which requires that moving a resident to another bedroom, work assignment, educational or program assignment with the goal of keeping them free safe from sexual abuse and sexual harassment. The facility is in compliance with this provision. 115.342 (b) The SHHRTC Zero Tolerance Policy prohibits the use of isolation, therefore SHHRTC avoids isolating residents due to risk of sexual victimization. During the onsite audit this auditor walked freely throughout the facility and was given access to all areas as requested. It was stated that the facility never places residents in isolation nor is the facility designed for such according to Truxillo House schematics. Furthermore, the programmatic design and service provided at this facility does not lend itself to provided isolation of its residents. This assertion was corroborated during the interviews with the Program Director and the direct care staff. The facility is in compliance with this provision. 115.342 (c) SHHRTC Executive Director/PREA Coordinator and the Intake staff indicated during their interview that SHHRTC does nor will not place Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) residents in a particular house, bed, or other assignment solely on the basis of such identification. SHHRTC reported on the PAQ of having zero LGBTI resident in the 12 months. The Program Director/PREA Compliance Manager indicated during her interview that if an LGBTI resident were in the program that SHHRTC would always refrain from considering lesbian, gay, bisexual, transgender, or intersex (LGBTI) identification or status as an indicator or likelihood of being sexually abusive. The facility is in compliance with this provision. 115.342 (d) SHHRTC is an all-male facility. The Intake Staff and the PAQ reported no LGBTI residents in the past 12 months. The Intake staff stated in her interview that the room/bed assignments would be made on a case by case basis and as with all

	residents assignments it would be based on ensuring the resident's health and safety, and whether placement would present management or security problems. SHHRTC reported on the PAQ of having zero transgender and intersex residents in the facility during the last 12 months. The facility is in compliance with this provision. 115.342 (e) At the time of this audit and in the last 12 months SHHRTC reported that there were no residents who identified as transgender or intersex at the facility. SHHRTC Zero Tolerance Policy does state that “transgender and intersex resident housing assignments and programing assignments would be reassessed at least twice each year to review any threats to safety experienced by the resident”. SHHRTC reported on the PAQ of having zero transgender and intersex resident in the 12 months and this was corroborated during the onsite visit file review. The facility is in compliance with this provision. 115.342 (f) SHHRTC Zero Tolerance Policy states that SHHRTC “would give serious consideration to the resident’s own views concerning their safety when making placement and programming assignments” for a transgender or intersex resident. SHHRTC reported on the PAQ of having zero transgender and intersex residents in the 12 months. The facility is in compliance with this provision. 115.342 (g) SHHRTC’s Zero Tolerance Policy states that it would “provide the opportunity for transgender and intersex residents to shower separately”. During the facility site review its auditors observed the shower areas, which are all single user showers behind a locked door for complete resident privacy, which in this house, would afford every resident the opportunity to shower separately from the other residents and with privacy. SHHRTC reported on the PAQ of having zero transgender and intersex residents in the 12 months which was corroborated during the onsite resident file review. The facility is in compliance with this provision. 115.342 (h) SHHRTC Executive Director/PREA Coordinator stated during her interview that they never place a resident in or utilizes isolation in this facility for the resident's safety or as an alternate means of separation from the general population. A review of the facility's programmatic mission statement and facility design corroborates this assertion. The facility is in compliance with this provision. 115.342 (I) SHHRTC Executive Director/PREA Coordinator stated during her interview that they never place a residents in or utilizes isolation and that the facility's schematics and programmatic design cannot this type of housing arrangement since this is a residential treatment facility. But if they were to designate a room or space for isolation purposes, every 30 days this status would be reviewed to determine whether there is a continuing need for the separation from the general population. The facility is in compliance with this provision. This facility is not configured nor its programmatic mission statement supports the use of isolation. This facility is in compliance with this provision. This facility is in compliance with this standard. Corrective Action Findings: None

115.351	Resident reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.351 (a) SHHRTC Zero Tolerance Policy states that SHHRTC “provides multiple internal ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff including staff neglect or violation of responsibilities that may have contributed to such incidents”. The SHHRTC Zero Tolerance Policy lists the following ways to report: (I) Submitting a written grievance, verbally or by any means the resident has access to; (ii) Calling the 24-hour toll free hotline 1 800-252-5400 without being heard by staff or other residents; (iii) Telling any staff member, volunteer, or contract employee who must then call the hotline and inform the Program Director or Executive Director; or (ii) Calling the toll-free number maintained by the Texas Department of Family Protective Services (TXDFPS) which is a separate state agency. Also, without being heard by staff or residents. During the interviews with the random residents they all indicated their knowledge of reporting a sexual abuse and sexual harassment, retaliation or staff neglect allegations by either telling a staff member, writing a grievance or calling the agency’s anonymous number that is listed in the PREA brochure. This auditor observed on the PREA brochure with the 1 800 and the agency’s anonymous number that a resident can call to report a sexual abuse and sexual harassment allegation or incident. During the random staff interviews they all indicated the ways a resident can report a sexual abuse and sexual harassment allegation by informing staff, writing a grievance, calling the 1800 number or the agency’s anonymous number that is directly to the Executive Director. The facility is in compliance with this provision. 115.351 (b) SHHRTC Zero Tolerance Policy states that “a residents may call the toll-free number maintained by the Texas Department of Family Protective Services (TXDFPS), 1 (800) 252-5400, which is a separate State agency to report a sexual abuse, sexual harassment, retaliation or staff neglect allegation. TXDFPS, according to the Executive Director/PREA Coordinator, does receive and immediately forwards these allegation calls to the Executive Director. A call was made to the TXDFPS hotline number and the operator confirmed this procedure for reporting back to the facility an alleged allegation of sexual abuse, sexual harassment and neglect. During the random resident interviews each one indicated that they could make this call in a private area, like the supervisor’s office, without being heard by the staff or other residents and that they could remain anonymous upon request.

	The Executive Director/PREA Coordinator did provide to this auditor during the pre-audit phase a memorandum stating that within the last 12 months there were no residents housed in this facility solely for civil immigration purposes. This assertion was also corroborated on the PAQ provided. The facility is in compliance with this provision. 115.351 (c) SHHRTC Zero Tolerance Policy states that staff will “promptly accepts verbal and written reports made a resident in person, anonymously or by third parties and the staff will promptly document any verbal reports”. During the interview with the random staff, when asked this question, each staff stated that they would accept verbal reports of sexual abuse and sexual harassment from a resident verbally, in writing, anonymously, from third parties and would document them immediately on the agency’s incident report form. A copy of the agency’s blank incident report form was provided to this auditor for his review during the pre-audit phase. The facility is in compliance with this provision. 115.351 (d) SHHRTC Zero Tolerance Policy states that SHHRTC will “provide residents access to grievance forms, paper, and writing instruments to privately make a written report of sexual abuse and sexual harassment”. During the interview with the random residents, they all indicated that they have access to paper, pencils and grievance forms if they want to report a sexual abuse and sexual harassment allegation in writing. This auditor was provided with a blank grievance form for his review during the pre-audit phase. While on the site review this auditor observed the availability of grievance forms and pencils for the resident’s usage and to whom/where they can submit these forms for resolution. The facility is in compliance with this provision. 115.351 (e) During the interviews with the random staff, they all indicated that they could report a sexual abuse, sexual harassment, and retaliation allegation against a resident privately by going to a supervisor’s office in person, calling them on the phone, calling the 1 800 number or by writing a note. The direct care staff supervisor during his interview as well as the agency's zero tolerance policy corroborated this assertion. The facility is in compliance with this provision. This facility is in compliance with this standard. Corrective Action Findings: None

115.352	**Exhaustion of administrative remedies**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.352 (a) The Executive Director/PREA Coordinator stated during her interview that SHHRTC does have an administrative procedure in place to address all resident grievances and does have an administrative remedy process to address sexual

	abuse. The facility is in compliance with this provision. 115.352 (b) SHHRTC Zero Tolerance Policy states that SHHRTC shall have “investigated all allegations of sexual abuse regardless of how much time has passed since the alleged incident” and that only the portion of the grievance not related to the allegation would be bound by a time limit according to the grievance policy. The Grievance policy states that “residents are not required to use any informal grievance process or otherwise attempt to resolve the allegation with staff, an alleged incident of sexual abuse”. During the interviews with the Executive Director/PREA Coordinator and the Program Director/PREA Compliance Manager corroborated this policy statement as a practice of refraining from requiring a resident to use any informal grievance process in an attempt to resolve with a sexual abuse or sexual harassment allegation with a staff member. Nothing in this section shall restrict the agency's ability to defend itself against a lawsuit filed by a resident on the grounds that the applicable statute of limitation has expired. The Intake staff stated during her interview that all residents are verbally informed of this procedure during intake. During the resident interviews they all stated that if they had a sexual abuse grievance that they would not seek resolution with that staff member but would make sure that the Executive Director received it for investigation and resolution. The facility is in compliance with this provision. 115.352 (c) SHHRTC Zero Tolerance Policy states 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 and that such grievances are not referred to a staff member who is the subject of a complaint for resolution”. During the interviews with the Executive Director/PREA Coordinator and the Program Director/PREA Compliance Manager corroborated this policy statement as a practice of refraining from requiring a resident to use any informal grievance process in an attempt to resolve with a sexual abuse or sexual harassment allegation with a staff member. The Intake staff stated during her interview that all residents are verbally informed of this procedure during the intake process. A review of the resident’s handbook does reflect the procedure of instructing the resident that they are not required to submit a grievance to a staff member who is the subject of the complaint”. The facility is in compliance with this provision. 115.352 (d) The Executive Director/PREA Coordinator indicated during her interview that the agency does 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. She also acknowledged that if they determined that the 90-day timeframe is insufficient that she would make an appropriate decision, claim an extension of time of not more than 70 days, and notify the resident in writing of any such extension and provide a date by which a decision will be made. She further stated that if the resident does not receive a response, they could consider the absence of a response to be a denial at that level and can then pursue outside ligation. During the interviews of the random residents, random staff, and a review of the grievances of the past 12 months, this auditor found zero grievances for sexual abuse or sexual harassment. The facility is in compliance with this provision.

	115.352 (e) SHHRTC Zero Tolerance Policy states that SHHRTC “accepts verbal and written reports made anonymously or by third parties and promptly documents verbal reports”. SHHRTC publicly distributes information on the agency’s website for third party reporting on behalf of a resident. According to SHHRTC’s Zero Tolerance Policy, third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, are permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse. Third party forms were observed and available to the public on the agency’s website as well as were provided to this auditor during the pre-audit phase. The Program Director/PREA Compliance Manager indicated during her interview that third parties are permitted to file such requests on behalf of residents, if a resident were to decline to have a third-party request processed on his behalf, that SHHRTC would document the resident’s decision. She further stated that SHHRTC accepts third party allegations and grievances from anyone, this includes appeals on behalf of the resident, from a parent or legal guardian. If the third party, other than a parent or guardian, files such a request on behalf of the resident, SHHRTC may require as a condition of processing the request that the alleged victim agree to have the request filed on his behalf., and may also require the alleged victim to personally pursue any subsequent steps in the administrative process. If the resident declines to have the request processed on his behalf, SHHRTC shall document the resident's decision. SHHRTC policy further states that if parent or guardian files such a request on behalf of the resident, including an appeal, such a grievance shall not be conditioned upon the resident agreeing to have the request filed on his behalf. The facility is in compliance with this provision. 115.352 (f) SHHRTC has an open-door policy to the Executive Director/PREA Coordinator, Program Director/PREA Compliance Manager and the Supervisor’s offices that a resident can file an emergency grievance alleging that they are subject to a substantial risk of imminent sexual abuse. During the interviews with the random staff, they all responded that if a resident submitted an emergency grievance or approached them indicating that they are at risk of imminent sexual abuse that they would take immediate action to keep the youth safe and immediately contact their supervisor. SHHRTC's Zero Tolerance policy corroborates this assertion. It was observed during the site review and throughout the onsite audit that SHHRTC’s administrators do maintain constant communication with their direct care staff and residents. That any grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, would be immediately reviewed at the highest level of the agency and then would be forwarded to TXDFPS Licensing Division and to the Harris County Sheriff Department for investigation. All staff interviewed mentioned separating a resident from a situation that had imminent risk of them being sexually abuse. The Executive Director/PREA Coordinator indicated that after receiving an emergency grievance, that she or the Program Director/PREA Compliance Manager would provide an initial response to the resident within 48 hours. The Executive Director/PREA Coordinator stated that any grievance related to sexual abuse and sexual harassment would immediately be forwarded to TXDFPS Licensing Division

	and the Harris County Sheriff Department and that they would issue a final decision within 5 calendar days. The Program Director/PREA Compliance Manager stated that they will provide to the resident, after the initial response to their emergency grievance, a final decision as to whether the resident is in substantial risk of imminent sexual abuse and the action to be taken in response to the emergency grievance. The facility is in compliance with this provision. 115.352 (g) SHHRTC's Zero Tolerance Policy states that the agency "may discipline a resident for filing a grievance related to alleged sexual abuse if the resident filed the grievance in bad faith". The SHHRTC Executive Director PREA Coordinator indicated during her interview that no resident had been disciplined for filing any grievance in bad faith. A review of the grievances filed over the past 12 months revealed that there were zero grievances alleging sexual abuse or sexual harassment. During the interviews the random residents they all reported feeling safe at SHHRTC and that they could file a sexual abuse or sexual harassment allegation without fear of retaliation. The facility is in compliance with this provision. The facility is in compliance with this standard Corrective Action Findings: None

115.353	**Resident access to outside confidential support services and legal representation**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.353 (a) The SHHRTC Zero Tolerance Policy states how all residents have "access to outside confidential support services related to sexual abuse and harassment by posting or otherwise making assessible mailing addresses and telephone numbers, including toll free numbers of local and national victim advocacy or rape crisis service organizations. The number for the Sexual Assault and Recovery Center (SARC) and the sexual abuse hotline were posted in the facility as observed by this auditor. SHHRTC Executive Director/PREA Coordinator stated that SHHRTC does provide the residents with access to representatives of such local, State, or national victim advocacy or rape crisis organizations" and that they do not detained residents solely for civil immigration purposes, therefore no postings or brochures include contact information for immigration services is required. During the interview with the random resident, 8 of 8 residents they confirmed that are able and have access to make a confidential call to an outside advocacy agency or rape crisis center and that the call would be private and confidential. The residents can call the DFPS hotline, SARC and or the national rape crisis hotline as needed. During the interview with the random staff, 11 of 11 staff interviewed confirmed that residents would be provided a private space to make a confidential

	phone call to any of these agencies upon request. This auditor observed during the site review in the house the following phone numbers posted on the bulletin board: · Sexual Assault Recovery Center 24-hour Crisis Hotline (SARC) (713-528-7273) · The Texas Department of Family and Protective Services (TXDFPS) (1- 800-252-5400) During the interview with the Intake staff she indicated that residents are also provided with information about SARC. A 'test call" was made to SARC and the representative reported that there were no calls on record from SHHRTC in the past 12 months requesting their services. She also indicated that the facility would receive an email notification if a sexual abuse allegation was made by a resident victim of this facility for further investigation. The facility is in compliance with this provision. 115. 353 (b) The Intake staff indicated during her interview that the residents are informed during intake the extent to which communications with these agencies will be monitored and the extent to which reports of sexual abuse being reported to them will be forwarded to the authorities in accordance to mandatory reporting laws. During the interviews with the random staff they all reported that they are mandated to report of sexual abuse and sexual harassment by state law. The intake staff and Program Director/PREA Compliance Manager interviewed acknowledged that the residents are informed of the mandatory reporting rules governing privacy, confidentiality, and/or privileges that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant Federal, State, or local law. The Intake staff indicated that verbal notification would be provided to the resident before discussing sexual abuse and sexual harassment allegation with the residents. SHHRTC random staff and management confirmed in during their respective interviews that the resident’s phone calls are not monitored or recorded. The facility is in compliance with this provision. 115.353 (c) SHHRTC did provide a copy of the Memorandum of Understanding sent to the Sexual Assault Resource Center (SARC) during the pre-audit phase, in an attempt to receive confidential services for resident victims of emotional support and victim services related to sexual abuse and sexual harassment. The SARC provide emotional support services to members of the public, including residents of SHHRTC, free of charge and can also be provided in-person or by phone. The facility is in compliance with this provision. 115.353 (d) SHHRTC’s Zero Tolerance Policy (3) (A-C) states that SHHRTC “does provide residents with reasonable and confidential access to their attorneys or legal representation, parents, and legal guardians”. During the site review this auditor observed the group rooms in each house (Truxillo and Wheeler) that is used for parental and legal visits. Parents, guardians and attorneys have reasonable access to the residents by contacting the facility to schedule a visit. During the random resident interviews each one explained that they could meet with their legal representatives, parents, and legal guardians in a confidential manner in the facility if required or requested by either party. The facility is in compliance with this

	provision. This facility is in compliance with this standard. Corrective Action Findings: None

115.354	Third-party reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.354 (a) The SHHRTC Zero Tolerance Policy does describes the procedures to receive and for making a 3rd party report of sexual abuse and harassment on behalf of a resident. This auditor was provided with a blank hard copy of the 3rd party report and he did observe the link regarding 3rd party reporting procedure on the agency website. The Executive Director/PREA Coordinator did provide a copy of the 3rd party reporting form during the pre-audit phase. She reported that there have been no 3rd party grievances of sexual abuse and harassment on behalf of a resident in the last 12 months. The facility is in compliance with this provision. This facility is in compliance with this standard. Corrective Action Findings: None

115.361	Staff and agency reporting duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.361 (a) SHHRTC’s Zero Tolerance Policy states that all staff “must immediately report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment, retaliation against residents or staff who reported an incident any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation whether or not it is part of the agency”. During the interviews with the random staff they all indicated that they have a duty to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment, retaliation against residents or staff who reported an incident any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation. This facility is in compliance with this provision 115.361 (b) SHHRTC Zero Tolerance Policy states that “all staff must comply with

	any applicable mandatory child abuse reporting laws in Texas Family Code Chapter 261 and other applicable professional licensure requirements". During the interviews with the random and specialized staff they all indicated that they are mandated by law to report sexual abuse allegations against a resident to the agency, the contracting and licensing agencies and to local law enforcement. This facility is in compliance with this provision 115.361 (c) SHHRTC Zero Tolerance Policy states that "staff are prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions". During the interviews with the random staff they all indicated that they would not inform other staff of an incident of sexual abuse or sexual harassment against a resident other than the extent necessary to make treatment, investigation and other security and management decisions. And they they would only report these incidents to the administrators, local agencies and officials who needed to know. This facility is in compliance with this provision 115.361 (d) SHHRTC does not have any medical staff but does have one contracting Psychotherapist who reported that he is required to report sexual abuse to the Executive Director, pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws. He further stated that he is required to inform residents of his duty to report, and the limitations of confidentiality, at the initiation of services. During the interview with the Program Director/PREA Compliance Manager she stated that each resident is informed of the limitations on confidentiality and her duty to report a sexual abuse, thereby corroborating the Psychotherapist's assertion. . This facility is in compliance with this provision 115.361 (e) Upon receiving any allegation of sexual abuse, the Executive Director/ PREA Coordinator and the Program Director/PREA Compliance Manager stated during their interviews that they would promptly report an allegation of sexual abuse to the Texas Department of Family Protective Services (TXDFPS) Licensing Division, to the Harris County Sheriff Department, the parent, guardian of the resident, if on probation, the juvenile court of jurisdiction including the probation officer and the resident's attorney of record. They indicated that in the last 12 months there have been no incidents of sexual abuse or sexual harassment to have occurred in the facility. A review of the resident's file corroborated this assertion. This facility is in compliance with this provision 115.361 (f) SHHRTC does not have facility designated investigators so all allegations of sexual abuse and sexual harassment, including 3rd party reports, are immediately reported to TXDFPS and the Harris County Sheriff Department which are the designated investigation agencies to conduct administrative and criminal sexual abuse investigations. The Executive Director/PREA Coordinator stated during her interview that there were no incidents of sexual abuse and sexual harassment to have occurred in or received by the facility in the last 12 months whether by 3rd party or anonymously that needed to be forwarded to the designated investigative

	entities. This facility is in compliance with this provision This facility is in compliance with this standard Corrective Acton Required: None

115.362	Agency protection duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.362 (a) SHHRTC Zero Tolerance Policy states that “upon receipt a resident is subject to a substantial risk if imminent sexual abuse, SHHRTC staff shall take immediate action to protect the youth”. During the interviews of the random staff and specialized staff they all described their responsibility and understanding that when they learn that a resident is subject to a substantial risk of imminent sexual abuse, that they must take immediate action to protect the resident. Because the facility does not utilize isolation, keeping the resident safe, separating the alleged victim from the alleged perpetrator, housing reassignment, providing one on one supervision, and removing the other person who is causing the imminent risk of sexual abuse or sexual harassment is their procedure according to the Executive Director/PREA Coordinator. She did provide a memorandum to corroborate this assertion. A review of the residents files did not reveal documentation of a resident being at risk of imminent sexual abuse in the last 12 months. The facility is in compliance with this provision. This facility is in compliance with this standard. Corrective Action: None

115.363	Reporting to other confinement facilities
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.363 (a)The SHHRTC Zero Tolerance Policy does state that SHHRTC Executive Director must immediately notify the agency head of the facility or appropriate office of the agency where the abuse occurred and that the head of the facility that receives the allegation would also notify the appropriate investigative agency.” The Executive Director/PREA Coordinator stated during her interview that she had not received an allegation from a resident during intake alleging that they were sexually abused at another facility in the last 12 months. She further stated that if she would have received one that upon receiving an allegation would notify TXDFPS

	immediately and then the head of the facility or appropriate office of the agency where the alleged abuse occurred. She did provide a memorandum to corroborate this assertion. The facility is in compliance with this provision 115.363 (b) The Executive Director/PREA Coordinator stated during her interview that she would make notification to the head of the facility where the abuse allegedly occurred within 72-hours after receiving the allegation. The Executive Director/PREA Coordinator stated during her interview that she had not received an allegation from a resident during intake alleging that they were sexually abused at another facility in the last 12 months. The facility is in compliance with this provision 115.363 (c) The Executive Director/PREA Coordinator stated during her interview that she would document the notification of sexual abuse related to another facility and maintain a record of it. The Executive Director/PREA Coordinator stated during her interview that she had not received an allegation from a resident during intake alleging that they were sexually abused at another facility in the last 12 months. The facility is in compliance with this provision 115.363 (d) The Executive Director/PREA Coordinator indicated during her interview that although there has not been an allegation made in the last 12 months, that she, during the notification process to the facility's head, would ask the facility head to ensure that it be investigated according to this standard. The facility is in compliance with this provision This facility is in compliance with this standard. Corrective Action Required: None

115.364	**Staff first responder duties**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.364 (a) SHHRTC Zero Tolerance Policy states that " upon learning a resident was sexually abused, the first staff member to respond to the report is required to separate the alleged victim and abuser, preserve and protect any crime scene until appropriate steps can be taken to collect any evidence and 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". During the interviews with the all of the random staff and first responders, they all indicated that they would separate the alleged victim and alleged abuser, preserve, protect the crime scene and evidence, and instruct the alleged victim and abuser not to take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth,

	changing clothes, urinating, defecating, smoking, drinking, or eating. A review of the Employee PREA Training curriculum by the Moss Group and “PREA: Your Role Responding to Sexual Abuse” from the NIC training portal corroborates the staff’s knowledge, interview response and duty. SHHRTC did not report any sexual abuse or sexual harassment allegations in the last 12 months. The facility is in compliance with this provision. 115.364 (b) The Executive Director/PREA Coordinator stated during her interview that all SHHRTC staff, including non-security staff, are trained as first responders and have the responsibility to separate the alleged victim from imminent risk, request that the alleged victim and perpetrator not take any actions that could destroy physical evidence as stated above, and then report the incident per policy to the Program Director/PREA Compliance Manager and to herself. SHHRTC did not report any sexual abuse and sexual harassment allegations in the last 12 months. The facility is in compliance with this provision. The facility is in compliance with this standard. Corrective Action Required: None

115.365	**Coordinated response**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.365 (a) The SHHRTC Zero Tolerance Policy does state that they “will maintain a written plan to coordinate the actions taken among first responders, mental health staff, administrators, and leadership”. The Executive Director/PREA Coordinator stated during her interview that she has developed and implemented the facility’s coordinated response plan in writing. The Program Director/PREA Compliance Manager corroborated this policy requirement during her interview. During the pre-audit phase she also provided this auditor a copy of their written coordination plan. During the interviews with the random and first responder staff they all described the responsibilities direct care and management staff in the event of a sexual abuse or sexual harassment allegation e.g. contact a supervisor, contact law enforcement who would transport the sexual abuse victim to the hospital, etc. in accordance to the written plan. The facility is in compliance with this provision. The facility is in compliance with this standard. Corrective Action Required: None

115.366	**Preservation of ability to protect residents from contact with abusers**

	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.366 (a) SHHRTC Zero Tolerance Policy states that SHHRTC “shall not enter into any agreement that limits its ability to remove alleged staff sexual abusers from contact with a resident pending the outcome of an investigation or determination of whether and to what extent discipline is warranted”. The Executive Director/PREA Coordinator indicated during her interview that SHHRTC does not employ unionized employees therefore they do not participate in collective bargaining and that she can remove an alleged sexual abusers from having contact with residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted. The Executive Director/PREA Coordinator did provide a memorandum to this auditor to corroborate this assertion. Upon review of the employee’s files there was no indication that if discipline was warranted, including removing an alleged sexual abuse staff member from contact with a resident, that SHHRTC was prevented from doing so due to a collective bargaining agreement. A review of the contractual agreements with Harrison, Tarrant, Dallas counties including TXDFPS do not prevent SHHRTC from removing an alleged staff sexual abuser from contact with a resident pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted. SHHRTC reported zero sexual abuse and sexual harassment allegations in the last 12 months. The facility is in compliance with this provision. 115.366 (b) SHHRTC Executive Director stated during her interview that there is nothing contained in the contractual agreements with TXDFPS, Tarrant, Harrison and Dallas counties that will prevent them from removing an alleged sexual abuser from having contact with a resident pending the outcome of an investigation, the conduct of the disciplinary process and that these agreements are not inconsistent with the provisions of 115.372 and 115.376 or that a no-contact assignment that is imposed pending the outcome of an investigation shall be expunged from or retained in the staff member's personnel file following a determination that the allegation of sexual abuse is not substantiated. SHHRTC reported zero sexual abuse and sexual harassment allegation and or investigations in the last 12 months. The facility is in compliance with this provision. This facility is in compliance with this standard. Corrective Action Required: None

115.367	**Agency protection against retaliation**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

	115.367 (a) SHHRTC Zero Tolerance Policy states that “retaliation by a resident against a residents and or staff member who report sexual abuse or sexual harassment or cooperate with an investigation is strictly prohibited”. The Executive Director/PREA Coordinator stated during her interview that the Program Director/ PREA Compliance Manager and the Staff Designated to monitor for Retaliation is the staff designated to monitoring retaliation against staff or residents that report sexual abuse or harassment. SHHRTC reported no sexual abuse and sexual harassment allegation and or investigations in the last 12 months therefore there was no action taken for monitoring for retaliation purposes. SHHRTC Executive Director/PRWA Coordinator did provide a memorandum to this auditor to corroborate this assertion. The facility is in compliance with this provision 115.367(b) SHHRTC Zero Tolerance Policy states that states they “will use multiple protection measures to protect the resident and staff from retaliation, such as housing transfers, removal of the alleged abuser from contact with the alleged victim, and emotional support services, for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations”. During the interview with the staff designated to monitor for retaliation they both indicated that they would protect the victim by removing the alleged staff and resident abuser from the program, place the staff abuser on administrative leave and would provide emotional support services to the alleged staff or resident abuser. Since SHHRTC reported no sexual abuse and sexual harassment allegation and or investigations in the last 12 months therefore there was no action needing to be taken for protective measure purposes. The facility is in compliance with this provision 115.367(c) SHHRTC Zero Tolerance Policy states that “ for at least 90 days (except when the allegation is unfounded), the designated staff members would monitor the reporter and the alleged victim for signs of retaliation including items such as conduct and treatment of the resident or staff who reported the sexual abuse to see if there are any changes to suggest possible retaliation by residents or staff disciplinary reports, housing or program changes, staff reassignments, negative performance reviews and conducts periodic status checks on the alleged victim”. During the interview with the Program Director/PREA Compliance Manager and the designated to monitor for retaliation, they both indicated that they would also monitor in all of the areas as stated above to protect the staff or resident who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with an investigation. They further stated that for at least 90 days following a report of sexual abuse that they would monitor the resident program changes, the reassignment of staff and would continue the monitoring beyond 90 days if the initial monitoring indicates a continuing need. SHHRTC did not report any monitoring of residents or staff for retaliation in the last 12 months. SHHRTC Executive Director provided a memorandum to corroborate this assertion. The facility is in compliance with this provision 115.367(d) SHHRTC Zero Tolerance Policy states that they would “conduct periodic status checks on the alleged victim”. During the interview with the Program Director/PREA Compliance Manager and the designated staff to monitor for

	retaliation, they both indicated they would conduct period status checks on the alleged victim daily. SHHRTC did not report any monitoring of residents or staff for retaliation in the last 12 months. The facility is in compliance with this provision 115.367 (e) SHHRTC Zero Tolerance Policy states that “if any other individual cooperates with an investigation expresses fear of retaliation, they would take appropriate measures to protect that individual against retaliation”. During the interview with the Program Director/PREA Compliance Manager and the designated staff to monitor for retaliation, they both indicated that if any other individual who cooperated with an investigation expresses fear of retaliation, that they would take appropriate measures to protect them also against retaliation. SHHRTC did not report any monitoring of residents or staff for retaliation in the last 12 months. The facility is in compliance with this provision 115.367(f) SHHRTC Executive Director stated during her interview that her agency's obligation to monitor for retaliation would terminate if the investigative entities determine that the allegation is unfounded. SHHRTC reported no sexual abuse and sexual harassment allegation and or investigations in the last 12 months therefore there was no need to monitor a resident and or staff for retaliation. The facility is in compliance with this provision. This facility is in compliance with this standard. Corrective Action Required: None

115.368	**Post-allegation protective custody**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.368 (a) SHHRTC Zero Tolerance Policy states that “SHHRTC does not use of segregated housing to protect a resident who is alleged to have suffered sexual abuse”. The Program Director/PREA Compliance Manager and the designated staff assigned to monitor against retaliation both stated during their interviews that SHHRTC does not use segregated housing and if the need ever arises for protecting a resident alleged to have suffered sexual abuse, that they would place the resident in another room, monitor them daily, and or removed them from placement in this facility to ensure their safety. During the site review and a review of the facility’s schematics, this auditor did not observe any areas in the Truxillo house that were designated or could be used to segregate a resident alleged to have suffered sexual abuse for their protection. During the interviews with the Program Director and the Executive Director they indicated that the facility's configuration and the programming designated for this facility, providing segregated housing to protect a resident is not possible. SHHRTC Executive Director did provide a memorandum to corroborate this assertion. The facility is in compliance with this provision

	This facility is in compliance with this standard. Corrective Action Required: None

115.371	Criminal and administrative agency investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.371 (a) SHHRTC Zero Tolerance Policy states that “SHHRTC does not conduct its own criminal or administrative investigations”. Criminal investigations are conducted by the Harris County Sheriff Department and administrative investigations are conduct by the Texas Department of Family and Protective Services (TXDFPS) Licensing Division. The Executive Director/PREA Coordinator did provide to this auditor during the pre-audit phase a copy of their contract with TXDFPS and in attempt, a copy of the Memorandum of Agreement with the Harris County Sheriff Department inclusive of their responsibilities for conducting investigations. SHHRTC reported zero administrative or criminal sexual abuse and sexual harassment investigations in the last 12 months that were conducted by either entity. The facility is in compliance with this provision 115.371 (b) SHHRTC Zero Tolerance Policy states that “SHHRTC does not conduct its own criminal or administrative investigations. Criminal investigations are conducted by the Harris County Sheriff Department and administrative investigations are conduct by the Texas Department of Family and Protective Services (TXDFPS) Licensing Division. The Executive Director/PREA Coordinator indicated during her interview that TXDFPS and the Harris County Sheriff Department personnel, to her understanding, have received training in conducting in conducting sexual abuse investigations involving juvenile victims in pursuant to 115.334. She also provided a memorandum to corroborate this assertion. The facility is in compliance with this provision 115.371 (c) SHHRTC Zero Tolerance Policy states that they do not conduct its own criminal or administrative investigations. Criminal investigations are conducted by the Harris County Sheriff Department and administrative investigations are conduct by the Texas Department of Family and Protective Services (TXDFPS) Licensing Division. The Executive Director/PREA Coordinator indicated during her interview that she believe that both the TXDFPS and Harris County Sheriff Department’s investigators would gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data, interview all alleged victims, suspected perpetrators and witnesses and would review all prior reports and complaints of sexual abuse involving the suspected perpetrator. The facility is in compliance with this provision 115.371 (d) The Executive Director/PREA Coordinator and the Program Director/ PREA Compliance Manager stated during their interviews that to their knowledge

	TXDFPS and the Harris County Sheriff Department would refrain from terminating an investigation solely because the source of the allegation recants the allegation. SHHRTC reported zero administrative and zero criminal investigations for sexual abuse and sexual harassment in the last 12 months. A file review corroborated this assertion. The facility is in compliance with this provision 115.371 (e) The Executive Director/PREA Coordinator and the Program Director/ PREA Compliance Manager stated during their interviews that to their knowledge the Harris County Sheriff Department would conduct interviews of all alleged victims, suspected perpetrators and witnesses as an agency practice and refer those cases where the evidence appears to support criminal prosecution to the local and or state prosecutor. The Executive Director/PREA Coordinator stated that to her knowledge, if the Harris County Sheriff Department believe that the quality of the evidence appears to support criminal prosecution, they would only conduct compelled interviews only after consulting with the local prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution. SHHRTC reported no sexual abuse and sexual harassment allegation and or investigations in the last 12 months. The facility is in compliance with this provision 115.371 (f) SHHRTC Executive Director/PREA Coordinator stated during her interview that she believes that the Harris County Sheriff Department would assess the credibility of an alleged victim, suspect, witness on an individual basis and not on the basis of the individual's status as a resident or staff and that the resident would not be required to submit to a polygraph examination or other truth telling device as a condition for proceeding with the investigation of such an allegation. The facility is in compliance with this provision 115.371 (g) SHHRTC does not conduct any type of administrative or criminal investigation. The Executive Director/PREA Coordinator stated during her interview that she believes that the Texas Department of Family Services Licensing Division (TXDFPS), will conduct all administrative investigations, to her knowledge, would include an effort to determine whether staff actions or failures to act contributed to the abuse. All administrative investigations would be documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind the credibility assessment and the investigative facts and findings. SHHRTC reported no administrative sexual abuse and sexual harassment allegation and or investigations in the last 12 months. The facility is in compliance with this provision 115.371 (h) SHHRTC does not conduct any type of administrative or criminal investigations and that in the last 12 months there were no criminal investigations conducted by the Harris County Sheriff Department. The Executive Director/PREA Coordinator stated during her interview that she believes that all criminal investigations would be documented in written reports that include a description thorough description of the physical evidence and testimonial evidence, the reasoning behind the credibility assessment and the investigative facts and findings inclusive of copies of all of the documentary evidence where feasible. SHHRTC

	reported no criminal investigations for sexual abuse and sexual harassment in the last 12 months. The facility is in compliance with this provision 115.371 (i) SHHRTC Zero Tolerance policy states that all substantiated allegations of conduct that appear to be criminal shall be referred for prosecution. The Executive Director/PREA Coordinator corroborated this assertion during her interview and reported no criminal investigations for sexual abuse in the last 12 months. The facility is in compliance with this provision. 115.371 (j) SHHRTC Zero Tolerance Policy states that they “maintains all written criminal and administrative reports for as long as the alleged abuser is in their program or employed by them, plus at least 5 years”. The Executive Director/PREA Coordinator stated during her interview SHHRTC will maintain all written criminal and administrative reports in accordance to paragraph (g) and (h) of this provision as long as the alleged abuser is incarcerated or employed by the agency, plus 5 years, unless the abuse was committed by a juvenile resident and applicable laws require a shorter period of retention. The facility is in compliance with this provision 115.371 (k) SHHRTC Zero Tolerance Policy states that they would encourage the TXDFPS or the Harris County Sheriff Department not to terminate an investigation solely on the basis that the alleged abuser or victim is no longer in their program or employed at the facility. This auditor found no evidence of TXDFPS and or the Harris County Sheriff Department doing such during the staff and resident file review while onsite. SHHRTC reported no sexual abuse and sexual harassment allegation and or investigations in the last 12 months. The facility is in compliance with this provision 115.371 (l) The Executive Director/PREA Coordinator stated during her interview that the Texas Department of Family and Protective Services (TXDFPS) Licensing Division is the State entity that would conduct administrative investigations that occur in this facility which would be conducted pursuant to the above requirements of this provision. SHHRTC reported no administrative allegations and investigation in the facility over the last 12 months. The facility is in compliance with this provision. 115.371 (m) SHHRTC Zero Tolerance Policy states that SHHRTC “would cooperate with the TXDFPS and the Harris County Sheriff Department investigators and will attempt to remain informed about the progress of the investigation”. The Executive Director/PREA Coordinator and Program Director both indicated during their interviews that they would fully cooperate with TXDFPS and the Harris County Sheriff Department regarding any investigation being conducted for sexual abuse and harassment and would remain involved until the investigation was completed. SHHRTC reported no administrative or criminal investigations in the last 12 months. The facility is in compliance with this provision The facility is in compliance with this standard. Corrective Action Required: None

115.372	Evidentiary standard for administrative investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.372 (a) SHHRTC Zero Tolerance Policy states that “in administrative investigations into allegation of sexual abuse or sexual harassment, the investigator’s findings must be based on a preponderance of evidence”. The Executive Director/PREA Coordinator did indicate during her interview that there were zero administrative investigations conducted by TXDFPS in the last 12 months and if there were the findings would be based on the preponderance of evidence. SHHRTC Executive Director did provide to this auditor a memorandum to corroborate this assertion. The facility is in compliance with this provision. The facility is in compliance with this standard Corrective Action Required: None

115.373	Reporting to residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.373 (a) SHHRTC’s Zero Tolerance Policy states following an investigation into a resident's allegation of sexual abuse suffered in the agency, SHHRTC will inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated or unfounded. SHHRTC will document all notifications and attempted notifications following an investigation into a resident’s allegation of sexual abuse suffered in this facility. This would include whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded”. The Executive Director/PREA Coordinator indicated during her interview that there were zero administrative and zero criminal investigations conducted for sexual abuse and sexual harassment in the last 12 months. The Executive Director did provide a memorandum to corroborate this assertion. There were no investigative file to review during the onsite audit phase. The facility is in compliance with this provision. 115.373 (b) SHHRTC Zero Tolerance Policy states that “following a resident’s allegation that a staff member will request the information from the investigating agency so the resident may be informed.” The Executive Director/PREA Coordinator stated during her interview that they would always request information from the TXDFPS and or the Harris County Sheriff Department to inform the resident of the investigation’s outcome. SHHRTC reported no sexual abuse and sexual harassment allegation and or investigations in the last 12 months. The facility is in compliance with this provision.

	115.373 (c) SHHRTC Zero Tolerance Policy states that “that following a resident’s allegation that a staff member committed sexual abuse against the resident, SHHRTC will inform the resident whenever the following events occur, except when the allegation is determined to be unfounded, or unless the resident has been released from the program, and that they will inform the resident whenever: · The staff member is no longer posted within the residents housing unit · The staff member is no longer employed at the facility · SHHRTC learns that the staff member has been indicted on a charge related to sexual abuse · Or SHHRTC learns that the staff member has been convicted on a charge related to the sexual abuse The Executive Director/PREA Coordinator stated during her interview that there have been no staff on resident sexual abuse allegations in the last 12 months. The facility is in compliance with this provision. 115.373 (d) SHHRTC Zero Tolerance Policy states that “following a resident’s allegation that he has been sexually abused by another resident, SHHRTC informs the alleged victim whenever the following events occur: · SHHRTC learns that the alleged abuser has been indicted on a charge related to the sexual abuse; or · SHHRTC learns that the alleged abuser has been convicted on a charge related to the sexual abuse. The Executive Director/PREA Coordinator stated during her interview that there has been no resident-on-resident sexual abuse allegations in the last 12 months that resulted in a resident abuser being indicted or convicted on a charge of sexual abuse. The facility is in compliance with this provision. 115.373 (e) The Executive Director/PREA Coordinator stated during her interview that she has and would continue to document and or attempt all notifications to residents regarding the outcome of an administrative or criminal sexual abuse investigation. SHHRTC reported no sexual abuse and sexual harassment allegation and or investigations in the last 12 months. The facility is in compliance with this provision. 115.371 (f) SHHRTC Zero Tolerance policy states that their obligation to report under this standard shall terminate if the resident is released from the agency's custody. SHHRTC reported no sexual abuse and sexual harassment allegation and or investigations in the last 12 months. The facility is in compliance with this provision. The facility is in compliance with this standard. Corrective Action Required: None

115.376	Disciplinary sanctions for staff
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.376 (a) SHHRTC's Zero Tolerance Policy states that "staff members are subject to disciplinary sanctions up to and including termination of employment for violating SHHRTC sexual abuse or sexual harassment policies". The Executive Director/PREA Coordinator stated during her interview that there have been no staff disciplinary actions taken against staff in the last 12 months for violating the Zero Tolerance policy. A review of the employee files revealed that no staff in the last 12 months had any disciplinary action taken against them for violating the Zero Tolerance policy. The facility is in compliance with this provision. 115.376 (b) SHHRTC's Zero Tolerance Policy states that "termination of employment is the presumptive disciplinary sanction for staff members who have engaged in sexual abuse". The Executive Director/PREA Coordinator stated during her interview that there have been no staff disciplinary actions taken against staff in the last 12 months for violating the Zero Tolerance policy. A review of the employee files revealed that no staff in the last 12 months had any disciplinary action taken against them for violating the Zero Tolerance policy. The Executive Director did provide to this auditor a memorandum to corroborate this assertion. The facility is in compliance with this provision. 115.376 (c) SHHRTC's Zero Tolerance Policy states that "disciplinary sanctions for violations of SHHRTC policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) will be commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. The Executive Director/PREA Coordinator stated during her interview that there have been no staff disciplinary actions taken against staff in the last 12 months for violating the Zero Tolerance policy. A review of the employee files revealed that no staff in the last 12 months had any disciplinary action taken against them for violating the Zero Tolerance policy. The facility is in compliance with this provision. 115.376 (d) SHHRTC's Zero Tolerance Policy, states that "SHHRTC would report the following actions to any relevant licensing body unless the activity was clearly not criminal: · Terminations of employment for violations of agency sexual abuse or sexual harassment policies; and · Resignations by staff members who would have been terminated if they had not resigned. The Executive Director/PREA Coordinator stated during her interview that there have been no staff disciplinary actions taken against staff in the last 12 months for violating the Zero Tolerance policy. A review of the employee files revealed that no

	staff in the last 12 months had any disciplinary action taken against them for violating the Zero Tolerance policy. The facility is in compliance with this provision. The facility is in compliance with this standard. Corrective Action Required: None

115.377	Corrective action for contractors and volunteers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.377(a) SHHRTC Zero Tolerance Policy states that “if a contractor or volunteer engages in sexual abuse, SHHRTC will: · Prohibit the contractor or volunteer from having any contact with SHHRTC resident; · And report the finding of abuse to any relevant licensing bodies. The Executive Director/PREA Coordinator stated during her interview that there have been no contractor and or volunteer disciplinary actions taken against any in the last 12 months for violating the Zero Tolerance policy. A review of the contractor files revealed that no contractor in the last 12 months had any disciplinary action taken against them for violating the Zero Tolerance policy. The Executive Director/ PREA Coordinator stated that there have been no volunteers working in the facility over the last 12 months. She also provided a memorandum to corroborate this assertion. The facility is in compliance with this provision 115.377(b) SHHRTC’s Zero Tolerance Policy states that SHHRTC will take appropriate remedial measures and consider whether to prohibit further contact of the contractor or volunteer with a SHHRTC resident”. The Executive Director/PREA Coordinator stated during her interview that there have been no contractor and or volunteer disciplinary actions taken against them in the last 12 months for violating the Zero Tolerance policy. A review of the contractor and volunteer files revealed that no contractor or volunteer in the last 12 months had any disciplinary action taken against them for violating the Zero Tolerance policy. The facility is in compliance with this provision The facility is in compliance with this standard Corrective Action Required: None

115.378	Interventions and disciplinary sanctions for residents
	Auditor Overall Determination: Meets Standard

	Auditor Discussion
	115.378 (a) SHHRTC's Zero Tolerance Policy states that states "a resident may be subject to disciplinary sanctions for engaging in sexual abuse only when: · There is a criminal finding of guilt or an administrative finding that the resident engaged in resident on resident sexual abuse; and · The discipline is determined through a due process hearing. The Executive Director/PREA Coordinator stated during her interview that there has been no resident has received disciplinary sanctions against them in the last 12 months for engaging in sexual abuse, violating the Zero Tolerance policy. A review of the resident files revealed that no resident in the last 12 months had any disciplinary sanctions against them for engaging in sexual abuse. She did provide to this auditor a memorandum to corroborate this assertion. The facility is in compliance with this provision. 115.378 (b) SHHRTC Zero Tolerance Policy states that "any disciplinary sanctions are commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories. The Executive Director/PREA Coordinator stated during her interview that there have been no disciplinary sanctions taken against a resident in the last 12 months for engaging in sexual abuse nor was any resident: · Denied daily large muscle exercise · Denied legally required educational programming or special education services · Denied daily visits from a medical or mental health care clinician · Denied access to other programs and work opportunities A review of the resident files revealed that no resident in the last 12 months had any disciplinary sanctions against them for engaging in sexual abuse. The facility is in compliance with this provision. 115.378 (c) SHHRTC Zero Tolerance Policy states that "when determining what types of sanctions, if any, should be imposed, that SHHRTC would consider whether a resident's mental disabilities or mental illness contributed to his behavior". The Executive Director/PREA Coordinator stated during her interview that there have been no disciplinary sanctions taken against a resident in the last 12 months for engaging in sexual abuse and that she would consider whether a resident's mental disabilities or mental illness contributed to his behavior when imposing disciplinary sanctions. The facility is in compliance with this provision. 115.378 (d) SHHRTC's Zero Tolerance Policy states that the facility does "offer resident abusers counseling and other interventions designed to address and correct underlying reasons or motivations for the abuse. SHHRTC may require

	participation in such counseling and interventions as a condition of access to behavior-based incentives, but not as a condition to access general programming or education". During the interview with the Program Director/PREA Compliance Manager who is also a mental health therapist, she indicates that she would offer therapy, counseling, or other intervention services to a resident victim, offending resident and that such participation in these interventions would not be a condition of access to any reward-based behavior management systems or other behavior-based incentives. She further stated that they do refrain from requiring a resident to participate in these services as a condition to access general programming and educational services. A review of the resident files revealed that no resident had been offered therapy, counseling or intervention services in the last 12 months. The facility is in compliance with this provision. 115.378 (e) SHHRTC's Zero Tolerance Policy states "a resident may be disciplined for sexual contact with staff only upon a finding that the staff member did not consent to such contact". During the interview with the Executive Director/PREA Coordinator she stated that no resident had been disciplined in the last 12 months for sexual contact with a staff member that did not consent to such contact. A review of the resident files revealed that no resident had been disciplined in the last 12 months for sexual contact with a staff member that did not consent to such contact. The facility is in compliance with this provision. 115.378 (f) SHHRTC's Zero Tolerance Policy states SHHRTC "may not discipline a resident if the resident made a report of sexual abuse in good faith based upon a reasonable belief that the alleged conduct occurred not constitute falsely reporting an incident of lying, even if an investigation does not establish evidence sufficient to substantiate the allegation". A review of the resident file revealed that no resident had been disciplined in the last 12 months for making a report of sexual abuse in good faith based upon a reasonable belief that the alleged conduct occurred. The facility is in compliance with this provision. 115.378 (g) SHHRTC's Zero Tolerance Policy states that SHHRTC "may also discipline a resident for engaging in prohibited sexual activity that does not meet the definition of abuse". During the interview with the Executive Director/PREA Coordinator she stated that no resident had been disciplined for engaging in prohibited sexual activity that does not meet the definition of sexual abuse. A review of the resident file revealed that no resident had been disciplined in the last 12 months for engaging in prohibited sexual activity that does not meet the definition of abuse. The facility is in compliance with this provision. This facility is in compliance with this standard. Corrective Action Required: None

115.381	**Medical and mental health screenings; history of sexual abuse**

	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.381 (a) SHHRTC Zero Tolerance Policy states that “if the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, that staff would ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening”. During the interview with the Intake staff she stated during her interview that there had been no residents in the last 12 months who indicated a prior sexual victimization in an institutional or community setting during the intake screening. A review of the resident files revealed that no resident who indicated during the intake screening that they had experience prior sexual victimization, whether it occurred in an institutional setting or in the community, was offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. The Executive Director did provide to this auditor a memorandum to corroborate this assertion. The facility is in compliance with this provision 115.381 (b) SHHRTC Zero Tolerance Policy states that “if the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, that staff would ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening”. During the interview with the Intake staff she stated during her interview that there had been no residents in the last 12 months who had previously perpetrated a sexual abuse in an institutional or community setting, as documented during the intake screening, required a referral to medical or mental health practitioner. A review of the resident files revealed that no resident had perpetrated a sexual abuse, whether it occurred in an institutional setting or in the community, was offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. The facility is in compliance with this provision 115.381 (c) The Executive Director/PREA Coordinator, Program Director/PREA Compliance Manager and the Intake staff all indicated during their interviews that any related sexual victimization or abusiveness that may occur in an institutional setting is strictly limited to mental health practitioners and the administrative management staff as necessary to inform them of treatment plans, security management decisions including housing, bed, work, education, and program assignments, or as otherwise required by federal, state, or local law. A review of the resident files revealed that no resident had any related sexual victimizations or abusiveness that occurred in an institutional setting or in the community, requiring a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. During the interviews with the random staff, they all indicated that they are only informed about a resident’s treatment plans and security management decisions as it pertains to housing, bed, work, education and program assignments. The facility is in compliance with this provision

	115.381 (d) SHHRTC's Zero Tolerance Policy states that "medical and mental health practitioners must obtain informed consent from resident before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18". A review of the resident's files revealed that all of the residents in SHHRTC are under the age of 18 and therefore the Psychotherapist is mandated by law to report any prior sexual abuse that did not occur in an institutional setting. The Executive Director/PREA Coordinator, Program Director/PREA Compliance Manager and the Intake staff all indicated during their interviews that they are mandated to report sexual abuse of a resident whether it occurred in an institutional setting or in the community. The facility is in compliance with this provision This facility is in compliance with this standard. Corrective Action Required: None

115.382	**Access to emergency medical and mental health services**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.382 (a) SHHRTC Zero Tolerance Policy states that "resident victims of sexual abuse will 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 judgement". The Executive Director/PREA Coordinator and the Program Director/PREA Compliance Manager stated during their interviews that a resident victim will receive and be provided 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 judgement. The Memorandum of Understanding with the SARC and a memorandum from the Executive Director on access to emergency medical and mental health services substantiated their assertion. The facility is in compliance with this provision 115.382 (b) SHHRTC Zero Tolerance Policy states that "If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, staff first responders take preliminary steps to protect the victim and must immediately notify the appropriate medical and mental health practitioner". The Executive Director/PREA Coordinator indicated during her interview that all staff have been trained as first responders who will immediately take steps to protect the victim, contact the Program Director/PREA Compliance Manager and the Harris County Sheriff Department, who would take the victim to the Texas Children's Hospital for medical and for mental health care through the Sexual Abuse Resource Center's (SARC) consortium services. During the interviews with the random staff and first responders, they all indicated that when they become aware that of a

	sexual abuse allegation, they would separate a victim from the perpetrator, contact their supervisor, call the hotline number, call law enforcement and keep the resident near them until their supervisor and law enforcement arrives. SHHRTC reported no sexual abuse and sexual harassment allegation and or investigations in the last 12 months. The facility is in compliance with this provision 115.382(c) SHHRTC's Zero Tolerance Policy states that a "resident victim would be provided timely information about and timely access to emergency contraception and sexually transmitted infection prophylaxis in accordance with professionally accepted standards of care, where medically appropriate". During the interview with the Program Director/PREA Compliance Manager, she stated that the Texas Children's Hospital provision of services through the Sexual Abuse Resource Center's (SARC) consortium would provide timely information about and timely access to emergency contraception and sexually transmitted infection prophylaxis to the resident victim. A review of the Memorandum of Understanding with the Texas Children's Hospital's provision of services through the Sexual Abuse Resource Center's (SARC) consortium services substantiated her assertion. SHHRTC Executive Director/PREA Coordinator reported that no residents had need of access to emergency medical or mental health services in the last 12 months. The facility is in compliance with this provision 115.382 (d) SHHRTC's Zero Tolerance Policy states "SHHRTC provides treatment services to the victim without cost and regardless of whether the victim names the abuser or cooperates with any investigation arising from the incident". The Texas Children's Hospital's SANE Nurse also indicated during her interview that forensic medical services are provided at no cost to a resident victim. A review of the Memorandum of Understanding with the Texas Children's Hospital's provision of services through the Sexual Abuse Resource Center's (SARC) consortium services supports the SANE nurse's assertion. The Program Director/PREA Compliance Manager also stated during her interview that the above services are provided at no cost to a resident victim and that no resident in the last 12 months required treatment services. The facility is in compliance with this provision This facility is in compliance with this standard. Corrective Action Required: None

115.383	**Ongoing medical and mental health care for sexual abuse victims and abusers**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.383(a) SHHRTC's Zero Tolerance Policy states that "SHHRTC offers medical and mental health evaluation and, as appropriate, treatment to all residents who have

	been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility". The Executive Director/PREA Coordinator indicated during her interview that medical and mental health evaluations and treatment would be provided to all residents who have been victimized by sexual abuse in a juvenile facility. She further indicated that here were no referrals made in the last 12 months for a resident to receive ongoing medical and mental health care as a sexual abuse victim or abuser. The Executive Director/PREA Coordinator did provide a memorandum to this auditor to corroborate this assertion. The facility is in compliance with this provision 115.383(b) SHHRTC Zero Tolerance Policy states that "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". The Executive Director/ PREA Coordinator indicated during her interview that residents, as appropriate, would receive follow-up services, treatment plans, and, when necessary, and referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. A review of the resident files indicated that no resident needed follow up services due to a sexual abuse when released from the facility. The facility is in compliance with this provision 115.383(c) SHHRTC's Zero Tolerance Policy states that states that "SHHRTC provides such victims with medical and mental health services consistent with the community level of care". The Executive Director/PREA Coordinator that the medical and mental health services that a resident sexual abuse victim would receive is consistent with the community level of care since they would be provided at the Texas Children's Hospital's provision of services through the Sexual Abuse Resource Center's (SARC) consortium. The facility is in compliance with this provision 115.383 (d) SHHRTC is an all-male facility, however in the event of the presence of a transgender male in their population, the Executive Director/PREA Coordinator indicated during her interview that a pregnancy test would be appropriate following any sexually abusive vaginal penetration. The SANE nurse at Texas Children's Hospital confirmed that they would offering pregnancy test, providing timely and comprehensive information about and to all lawful pregnancy related medical services, and testing for sexually transmitted infections to a sexual abuse victim resident as part of their protocol. SHHRTC reported no transgender or intersex residents in their population for the last 12 months. The facility is in compliance with this provision 115.383 (e) SHHRTC is an all-male facility, however in the event of the presence of a transgender male in their population, the Executive Director/PREA Coordinator indicated during her interview that a resident would receive timely and comprehensive information about and timely access to all lawful pregnancy related medical services following any sexually abusive vaginal penetration. The SANE nurse at Texas Children's Hospital confirmed that they would offering pregnancy test, providing timely and comprehensive information about and to all lawful pregnancy related medical services, and testing for sexually transmitted infections

	to a sexual abuse victim resident as part of their protocol. The facility is in compliance with this provision 115.383 (f) SHHRTC Zero Tolerance Policy states that “SHHRTC will ensure that tests for sexually transmitted infections are offered, as medically appropriate, to resident victims of sexual abuse while in their facility”. The SANE nurse at Texas Children’s Hospital confirmed that they would ensure that tests for sexually transmitted infections are offered, as medically appropriate, to resident victims of sexual abuse. A review of the resident files revealed that no resident had been referred to the Texas Children’s Hospital for tests for sexually transmitted infections as a sexual abuse victim in the last 12 months. The facility is in compliance with this provision 115.383 (g) According to SHHRTC’s Zero Tolerance Policy states that “SHHRTC provides treatment services to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising from the incident.” the Executive Director/PREA Coordinator indicated during her interview that all services received by a resident referred to the Texas Children’s Hospital would be at no cost to the resident. A review of the resident files revealed that no resident had been referred to the Texas Children’s Hospital for any of their services in the last 12 months. There were no residents in the population to interview who had been referred to the Texas Children’s Hospital in the last 12 months. The facility is in compliance with this provision 115.383(h) SHHRTC Zero Tolerance Policy states that “SHHRTC attempts 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”. The Program Director/PREA Compliance Manager and the Mental Health Practitioner did indicate during their interviews that once they learn or become aware of a known resident on resident abuser’s abuse history, that within 60 days they would refer the resident to mental health practitioners. They also stated that they would conduct a mental health evaluation and offer treatment upon learning of such abuse history. SHHRTC reported no sexual abuse and sexual harassment allegation and or investigations in the last 12 months therefore there were no mental health evaluations conducted. This facility is in compliance with this provision The facility is in compliance with this standard Corrective Action Required: None

115.386	**Sexual abuse incident reviews**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.386 (a) SHHRTC’s Zero Tolerance Policy states that “SHHRTC 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". The Executive Director/PREA Coordinator stated during her interview that a sexual abuse incident review would be conducted at the conclusion of every sexual abuse investigation, including for allegations that are Unsubstantiated, unless the allegation has been determined to be Unfounded. SHHRTC reported zero allegation for sexual abuse and sexual harassment in the last 12 months. Program Director/PREA Compliance Manager did provide a memorandum from the Executive Director indicating that in the last 12 months there were no sexual abuse incident reviews that occurred. She did provide a memorandum to this auditor to corroborate this assertion. A review of the resident, employee and investigative records revealed that there were no allegations of sexual abuse that occurred in the last 12 months. The facility is in compliance with this provision 115.386 (b) SHHRTC Zero Tolerance Policy states that SHHRTC conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, within 30 days, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded. The Program Director/PREA Compliance Manager indicated that there was no sexual abuse incident review in the last 12 months due to having no sexual abuse investigative findings of Unsubstantiated or Substantiated. A review of the resident, employee and investigative records revealed that there were no Unsubstantiated or Substantiated allegation of sexual abuse that occurred in the last 12 months. The Executive Director/PREA Coordinator did provide to this auditor a memorandum to corroborate this assertion. The facility is in compliance with this provision 115.386 (c) The SHHRTC incident review team includes upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners. The SHHRTC team consists of the following individuals: a. Executive Director/ PREA Coordinator b. Program Director/PREA Compliance Manager c. Supervisor d. Contracting Mental Health Practitioner During the interviews with the Program Director/PREA Compliance Manager and a member of the Incident Review Team, they stated that once a meeting would convene, that input would be provided by them regarding how to prevent further incidents of sexual abuse and sexual harassment from occurring. A review of the resident, employee and investigative records revealed that there were no Unsubstantiated or Substantiated allegation of sexual abuse that occurred in the last 12 months. The facility is in compliance with this provision 115.386(d) SHHRTC Zero Tolerance Policy states that SHHRTC would:

	· Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse. · Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility. · Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse. · Assess the adequacy of staffing levels in that area during different shifts. · Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff. · Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1)- (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA Compliance Manager. The Executive Director/PREA Coordinator did provide a memorandum stating that over the last 12 months that there were no sexual abuse incident reviews due to there being no sexual abuse and sexual harassment allegations being made and no sexual abuse investigative findings of Unsubstantiated or Substantiated. The facility is in compliance with this provision 115.386 (e) SHHRTC Zero Tolerance Policy states that “SHHRTC would submit a report of its findings to the Executive Director and other appropriate staff to implement the recommendations for improvement, or document its reasons for not doing so”. The Program Director/PREA Compliance Manager did provide to this auditor a memorandum indicating that in the last 12 months there were no sexual abuse incident reviews held due to there being no sexual abuse allegations or investigations occurring in the facility. The facility is in compliance with this provision This facility is in compliance with this standard. Corrective Action Required: None

115.387	**Data collection**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.387(a) SHHRTC’s Zero Tolerance Policy states that “SHHRTC collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control

	using a standardized instrument and set of definitions. The Program Director/PREA Compliance Manager indicated during her interview that they do collect accurate data on every allegation from facilities under their control using a standardized instrument and set of definitions. SHHRTC were no reported sexual abuse and sexual harassment allegations in the last 12 months and this data has been placed on a spreadsheet for future reporting purposes. The facility is in compliance with this provision 115.387 (b) SHHRTC Zero Tolerance Policy states that “SHHRTC collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions and aggregates the data at least once each year”. During the interviews with the Executive Director/PREA Coordinator and the Program Director/PREA Compliance Manager it was ascertained that they had aggregated this incident annually that occurred in calendar year of 2020, 2021 and 2022 for the last 3 years. A memorandum for their annual report was provided to corroborate this assertion. This facility is in compliance with this provision. 115.387 (c) The Executive Director/PREA Coordinator and the Program Director/ PREA both indicated during their interviews that they do not participate in the Survey of Sexual Violence conducted by the Department of Justice (DOJ) but if they did, their incident based data would include the data necessary to answer the questions on the said survey. The facility is in compliance with this provision 115.387 (d) The Executive Director/PREA Coordinator and the Program Director/ PREA both indicated during their interviews that they would and do maintain, review, and collect data as needed from available incident-based documents, including reports, investigation files and sexual abuse incident reviews. They further indicated that the data collected thus far is based on there being zero allegations and investigations of sexual abuse and sexual harassment in the last 12 months. The facility is in compliance with this provision 115.387 (e) The Executive Director/PREA Coordinator and the Program Director/ PREA both indicated during their interviews that they do not contract for the confinement of their residents with another private facility therefore no incident based aggregate data is collected. The facility is in compliance with this provision 115.387 (f) The Executive Director/PREA Coordinator and the Program Director/PREA both indicated during their interviews that they would provide, upon request, all such data from the previous calendar year to the Department of Justice no later than June 30. They further stated that DOJ has not requested agency data in the last 3 years as well as in the 12 months. The facility is in compliance with this provision This facility is in compliance with this standard. Corrective Action: None

115.388	**Data review for corrective action**

	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.388 (a) The Program Director/PREA Compliance Manager stated during her interview that she has and would review any and all data collected and aggregated pursuant to § 115.387 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 · Taking corrective action on an ongoing basis. She stated that she had collected and prepared an annual report for 2020, 2021 and 2022 of her findings and recommended no corrected action be taken for Truxillo house. She further stated that the during the previous 3 years that there were no sexual abuse and sexual harassment allegations made, including in the last 12 months in this facility. The facility is in compliance with this provision. 115.388 (b) The Program Director/PREA Compliance Manager stated during her interview that she does compare the current year's data and corrective actions, which were none, with those from prior years, which were none, thereby providing an assessment of the agency's progress in addressing sexual abuse. The facility is in compliance with this provision as indicated per 115.388 (a). The facility is in compliance with this provision 115.388 (c) The Program Director/PREA Compliance Manager stated during her interview that the annual reports would be approved by the Executive Director and made readily available to the public though the agency's website. These reports are currently posted on the agency's website as observed by this auditor. This facility is in compliance with this provision 115.388 (d) The Program Director/PREA Compliance Manager stated did complete an annual report for 2022,that this annual report would indicate the nature of the material redacted and 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. The facility is in compliance with this provision as indicated per 115.387. The facility is in compliance with this provision The facility is in compliance with this standard Corrective Action: None .

115.389	**Data storage, publication, and destruction**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

	115.389 (a) SHHRTC's Zero Tolerance Policy states that the "SHHRTC will collect and retain sexual abuse and sexual harassment data in a secure manner". The Program Director/PREA Compliance Manager indicated during her interview that all sexual abuse and sexual harassment data collected will be securely retained pursuant to 115.387. She further stated that this information is securely retained in the Executive Director's office under lock and key and it was observed as such by this auditor during the onsite visit. The facility is in compliance with this provision 115.389 (b) The Program Director/PREA Compliance Manager indicated during her interview that all aggregated sexual abuse data, from facilities under its direct control, though they do not contract for confinement of their residents to another private facility, would and have made it readily available to the public through the agency's website www.shamarhopehaven.org. This auditor did review the agency's website and did observe these annual reports posted. This facility is in compliance with this provision. 115.389 (c) The Program Director/PREA Compliance Manager stated during her interview that she once she completed the annual report for 2022, that she had all of the personal identifiers removed before making the aggregated sexual abuse data available to the public though the agency's website. Since there were no sexual abuse or sexual harassment data available due to no sexual abuse and sexual harassment allegations being made, there was no need for the removal of personal identifiers, since there were none, before making these reports available to the public on the agency's website. The facility is in compliance with this provision 115.389 (d) The Program Director/PREA Compliance Manager stated during her interview SHHRTC would maintain all sexual abuse data collect pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise. The annual reports from 2020, 2021 and 2022 have been posted on the agency's website pursuant to this standard's requirement. The Executive Director/PREA Coordinator did provide a memorandum to corroborate this assertion. The facility is in compliance with this provision This facility is in compliance with this standard Corrective Action: None

115.401	**Frequency and scope of audits**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.401(a) The Program Director/PREA Compliance Manager stated during her interview that the Truxillo House was audited at least once on August 24th, 2020. SHHRTC did provide a copy of the Final Report to this auditor to corroborate this

	assertion. The facility is in compliance with this provision 115.401 (b) The Executive Director/PREA Coordinator and the Program Director/ PREA Compliance Manager both stated during their interview that this is the 3rd PREA audit tat this facility has underwent since 2017. The previously closed facility, the Wheeler House, which was its second facility, had been audited in accordance with this provision prior to its closure. The facility is in compliance with this provision 115.401 (h) During the onsite phase of this audit this auditor did have access to, and the ability to observe, relevant documentation including those electronically stored information, was able to retain and preserve all documentation, DVDs, relied upon in the OAS, access to all areas of SHHRTC's administrative building, Truxillo house; and access to all its residents, staff and contractors. The facility is in compliance with this provision 115.401 (I) During the onsite phase of this audit this auditor was permitted to request, receive and retain copies of any relevant document including electronically stored information from SHHRTC's administrative office, its files and records from Truxillo house. The facility is in compliance with this provision 115.401 m. During the onsite phase of this audit this auditor was able to conduct interviews with the residents in a private setting (e.g. an office with a door) in the facility and at the administrative building. The facility is in compliance with this provision 115.401 n. During the pre-audit, onsite and post-audit phase of this audit, residents were and are permitted to send confidential information or correspondence to this auditor in the same manner as if they were communicating with legal counsel. As of the writing of this report, this auditor has not received any confidential information or correspondence from a resident and or staff from Truxillo house to date. The facility is in compliance with this provision This facility is in compliance with this standard. Corrective Action Required: None

115.403	**Audit contents and findings**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.403 (f) A review of SHHRTC's website revealed that they were previously audited. The dates of the facility visit were January 8th- January 10th, 2020. A Final PREA Audit Report was issued by Certified PREA Auditor Jerome K Williams on August 24th, 2020. A review of SHHRTC's website revealed that the Final Audit Report for this timeframe and of the previous audits were posted on the agency's

	website at www.shamarhopehaven.org. The Executive Director/PREA Coordinator has been informed by this auditor that this report, in its final form when issued, must be posted also on the agency's website within 90 days of its issuance as were the other final reports. This facility is in compliance with this provision. This facility is in compliance with this standard. Corrective Action: None

Appendix: Provision Findings		
115.311 (a)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment?	yes
	Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment?	yes
115.311 (b)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Has the agency employed or designated an agency-wide PREA Coordinator?	yes
	Is the PREA Coordinator position in the upper-level of the agency hierarchy?	yes
	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
115.311 (c)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.)	yes
	Does the PREA compliance manager have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards? (N/A if agency operates only one facility.)	yes
115.312 (a)	**Contracting with other entities for the confinement of residents**	
	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 adopt and 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
115.312 (b)	**Contracting with other entities for the confinement of residents**	

	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 OR the response to 115.312(a)-1 is "NO".)	na
115.313 (a)	**Supervision and monitoring**	
	Does the agency ensure that each facility has developed a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility has implemented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility has documented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The prevalence of substantiated and unsubstantiated incidents of sexual abuse?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Generally accepted juvenile detention and correctional/secure residential practices?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any judicial findings of inadequacy?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from Federal investigative agencies?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate	yes

	staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies?	
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The composition of the resident population?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The number and placement of supervisory staff?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Institution programs occurring on a particular shift?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any applicable State or local laws, regulations, or standards?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any other relevant factors?	yes
115.313 (b)	**Supervision and monitoring**	
	Does the agency comply with the staffing plan except during limited and discrete exigent circumstances?	yes
	In circumstances where the staffing plan is not complied with, does the facility fully document all deviations from the plan? (N/A if no deviations from staffing plan.)	na
115.313 (c)	**Supervision and monitoring**	
	Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.)	yes

	Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.)	yes
	Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A only until October 1, 2017.)	yes
	Does the facility ensure only security staff are included when calculating these ratios? (N/A only until October 1, 2017.)	yes
	Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph?	yes
115.313 (d)	**Supervision and monitoring**	
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The staffing plan established pursuant to paragraph (a) of this section?	yes
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns?	yes
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The facility’s deployment of video monitoring systems and other monitoring technologies?	yes
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan?	yes
115.313 (e)	**Supervision and monitoring**	
	Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities)	na
	Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities)	na
	Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational	na

	functions of the facility? (N/A for non-secure facilities)	
115.315 (a)	**Limits to cross-gender viewing and searches**	
	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
115.315 (b)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances?	yes
115.315 (c)	**Limits to cross-gender viewing and searches**	
	Does the facility document and justify all cross-gender strip searches and cross-gender visual body cavity searches?	yes
	Does the facility document all cross-gender pat-down searches?	yes
115.315 (d)	**Limits to cross-gender viewing and searches**	
	Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks?	yes
	Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit?	yes
	In facilities (such as group homes) that do not contain discrete housing units, 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? (N/A for facilities with discrete housing units)	yes
115.315 (e)	**Limits to cross-gender viewing and searches**	
	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
	If a resident’s genital status is unknown, does the facility	yes

	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?	
115.315 (f)	**Limits to cross-gender viewing and searches**	
	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
	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
115.316 (a)	**Residents with disabilities and residents who are limited English proficient**	
	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
	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
	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
	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
	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:	yes

	Residents who have speech disabilities?	
	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
	Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing?	yes
	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
	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
	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
	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: Who are blind or have low vision?	yes
115.316 (b)	**Residents with disabilities and residents who are limited English proficient**	
	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
	Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes
115.316 (c)	**Residents with disabilities and residents who are limited English proficient**	
	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	yes

	safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations?	
115.317 (a)	**Hiring and promotion decisions**	
	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
	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
	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 bullet immediately above?	yes
	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
	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
	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 two bullets immediately above?	yes
115.317 (b)	**Hiring and promotion decisions**	
	Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents?	yes
115.317	**Hiring and promotion decisions**	

(c)		
	Before hiring new employees who may have contact with residents, does the agency: Perform a criminal background records check?	yes
	Before hiring new employees who may have contact with residents, does the agency: Consult any child abuse registry maintained by the State or locality in which the employee would work?	yes
	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
115.317 (d)	**Hiring and promotion decisions**	
	Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents?	yes
	Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents?	yes
115.317 (e)	**Hiring and promotion decisions**	
	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
115.317 (f)	**Hiring and promotion decisions**	
	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
	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	yes

	employees?	
	Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct?	yes
115.317 (g)	**Hiring and promotion decisions**	
	Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination?	yes
115.317 (h)	**Hiring and promotion decisions**	
	Unless prohibited by law, 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
115.318 (a)	**Upgrades to facilities and technologies**	
	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.)	na
115.318 (b)	**Upgrades to facilities and technologies**	
	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.)	na
115.321 (a)	**Evidence protocol and forensic medical examinations**	

	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.)	na
115.321 (b)	**Evidence protocol and forensic medical examinations**	
	Is this protocol developmentally appropriate for youth? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)	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.)	na
115.321 (c)	**Evidence protocol and forensic medical examinations**	
	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
	Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible?	yes
	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
	Has the agency documented its efforts to provide SAFEs or SANEs?	yes
115.321 (d)	**Evidence protocol and forensic medical examinations**	
	Does the agency attempt to make available to the victim a victim advocate from a rape crisis center?	yes

	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?	yes
	Has the agency documented its efforts to secure services from rape crisis centers?	yes
115.321 (e)	**Evidence protocol and forensic medical examinations**	
	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
	As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals?	yes
115.321 (f)	**Evidence protocol and forensic medical examinations**	
	If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating entity follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency is responsible for investigating allegations of sexual abuse.)	na
115.321 (h)	**Evidence protocol and forensic medical examinations**	
	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? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.321(d) above.)	na
115.322 (a)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse?	yes
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment?	yes

115.322 (b)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency have a policy 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
	Has the agency published such policy on its website or, if it does not have one, made the policy available through other means?	yes
	Does the agency document all such referrals?	yes
115.322 (c)	**Policies to ensure referrals of allegations for investigations**	
	If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for criminal investigations. See 115.321(a))	yes
115.331 (a)	**Employee training**	
	Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment?	yes
	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
	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
	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
	Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in juvenile facilities?	yes
	Does the agency train all employees who may have contact with residents on: The common reactions of juvenile victims of sexual abuse and sexual harassment?	yes

	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 and how to distinguish between consensual sexual contact and sexual abuse between residents?	yes
	Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents?	yes
	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
	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
	Does the agency train all employees who may have contact with residents on: Relevant laws regarding the applicable age of consent?	yes
115.331 (b)	**Employee training**	
	Is such training tailored to the unique needs and attributes of residents of juvenile facilities?	yes
	Is such training tailored to the gender of the residents at the employee's facility?	yes
	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
115.331 (c)	**Employee training**	
	Have all current employees who may have contact with residents received such training?	yes
	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
	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

115.331 (d)	**Employee training**	
	Does the agency document, through employee signature or electronic verification, that employees understand the training they have received?	yes
115.332 (a)	**Volunteer and contractor training**	
	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
115.332 (b)	**Volunteer and contractor training**	
	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
115.332 (c)	**Volunteer and contractor training**	
	Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received?	yes
115.333 (a)	**Resident education**	
	During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment?	yes
	During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment?	yes
	Is this information presented in an age-appropriate fashion?	yes
115.333 (b)	**Resident education**	
	Within 10 days of intake, does the agency provide age-appropriate	yes

	comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment?	
	Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents?	yes
	Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents?	yes
115.333 (c)	**Resident education**	
	Have all residents received such education?	yes
	Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility?	yes
115.333 (d)	**Resident education**	
	Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are deaf?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills?	yes
115.333 (e)	**Resident education**	
	Does the agency maintain documentation of resident participation in these education sessions?	yes
115.333 (f)	**Resident education**	

	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
115.334 (a)	**Specialized training: Investigations**	
	In addition to the general training provided to all employees pursuant to §115.331, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received 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 115.321(a).)	na
115.334 (b)	**Specialized training: Investigations**	
	Does this specialized training include: Techniques for interviewing juvenile sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	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 115.321(a).)	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 115.321(a).)	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 115.321(a).)	na
115.334 (c)	**Specialized training: Investigations**	
	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 115.321(a).)	na

115.335 (a)	**Specialized training: Medical and mental health care**	
	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
	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
	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 juvenile 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
	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
115.335 (b)	**Specialized training: Medical and mental health care**	
	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 medical staff at the facility do not conduct forensic exams or the agency does not employ medical staff.)	na
115.335 (c)	**Specialized training: Medical and mental health care**	
	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

115.335 (d)	**Specialized training: Medical and mental health care**	
	Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? (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
	Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? (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
115.341 (a)	**Obtaining information from residents**	
	Within 72 hours of the resident's arrival at the facility, does the agency obtain and use information about each resident's personal history and behavior to reduce risk of sexual abuse by or upon a resident?	yes
	Does the agency also obtain this information periodically throughout a resident's confinement?	yes
115.341 (b)	**Obtaining information from residents**	
	Are all PREA screening assessments conducted using an objective screening instrument?	yes
115.341 (c)	**Obtaining information from residents**	
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Prior sexual victimization or abusiveness?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Current charges and offense history?	yes
	During these PREA screening assessments, at a minimum, does	yes

	the agency attempt to ascertain information about: Age?	
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Level of emotional and cognitive development?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical size and stature?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Mental illness or mental disabilities?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Intellectual or developmental disabilities?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical disabilities?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: The resident’s own perception of vulnerability?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents?	yes
115.341 (d)	**Obtaining information from residents**	
	Is this information ascertained: Through conversations with the resident during the intake process and medical mental health screenings?	yes
	Is this information ascertained: During classification assessments?	yes
	Is this information ascertained: By reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident’s files?	yes
115.341 (e)	**Obtaining information from residents**	
	Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked	yes

	pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents?	
115.342 (a)	**Placement of residents**	
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Housing Assignments?	yes
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Bed assignments?	yes
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Work Assignments?	yes
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Education Assignments?	yes
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Program Assignments?	yes
115.342 (b)	**Placement of residents**	
	Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged?	yes
	During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise?	yes
	During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services?	yes
	Do residents in isolation receive daily visits from a medical or mental health care clinician?	yes
	Do residents also have access to other programs and work opportunities to the extent possible?	yes

115.342 (c)	**Placement of residents**	
	Does the agency always refrain from placing: Lesbian, gay, and bisexual residents in particular housing, bed, or other assignments solely on the basis of such identification or status?	yes
	Does the agency always refrain from placing: Transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status?	yes
	Does the agency always refrain from placing: Intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status?	yes
	Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator or likelihood of being sexually abusive?	yes
115.342 (d)	**Placement of residents**	
	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
	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
115.342 (e)	**Placement of residents**	
	Are placement and programming assignments for each transgender or intersex resident reassessed at least twice each year to review any threats to safety experienced by the resident?	yes
115.342 (f)	**Placement of residents**	
	Are each transgender or intersex resident’s own views with respect to his or her own safety given serious consideration when	yes

	making facility and housing placement decisions and programming assignments?	
115.342 (g)	**Placement of residents**	
	Are transgender and intersex residents given the opportunity to shower separately from other residents?	yes
115.342 (h)	**Placement of residents**	
	If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A for h and i if facility doesn't use isolation?)	na
	If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A for h and i if facility doesn't use isolation?)	na
115.342 (i)	**Placement of residents**	
	In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS?	yes
115.351 (a)	**Resident reporting**	
	Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: 2. Retaliation by other residents or staff for reporting sexual abuse and sexual harassment?	yes
	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
115.351 (b)	**Resident reporting**	
	Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private	yes

	entity or office that is not part of the agency?	
	Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials?	yes
	Does that private entity or office allow the resident to remain anonymous upon request?	yes
	Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment?	yes
115.351 (c)	**Resident reporting**	
	Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties?	yes
	Do staff members promptly document any verbal reports of sexual abuse and sexual harassment?	yes
115.351 (d)	**Resident reporting**	
	Does the facility provide residents with access to tools necessary to make a written report?	yes
115.351 (e)	**Resident reporting**	
	Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents?	yes
115.352 (a)	**Exhaustion of administrative remedies**	
	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.	no
115.352 (b)	**Exhaustion of administrative remedies**	

	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
	Does the agency always refrain from requiring an 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
115.352 (c)	**Exhaustion of administrative remedies**	
	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
	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
115.352 (d)	**Exhaustion of administrative remedies**	
	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
	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 115.352(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
	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
115.352 (e)	**Exhaustion of administrative remedies**	

	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
	Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.)	yes
	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
	Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.)	yes
	If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.)	yes
115.352 (f)	**Exhaustion of administrative remedies**	
	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
	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
	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

	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
	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
	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
	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
115.352 (g)	**Exhaustion of administrative remedies**	
	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
115.353 (a)	**Resident access to outside confidential support services and legal representation**	
	Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations?	yes
	Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies?	yes
	Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible?	yes
115.353 (b)	**Resident access to outside confidential support services and legal representation**	
	Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and	yes

	the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws?	
115.353 (c)	**Resident access to outside confidential support services and legal representation**	
	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
	Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements?	yes
115.353 (d)	**Resident access to outside confidential support services and legal representation**	
	Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation?	yes
	Does the facility provide residents with reasonable access to parents or legal guardians?	yes
115.354 (a)	**Third-party reporting**	
	Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment?	yes
	Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident?	yes
115.361 (a)	**Staff and agency reporting duties**	
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency?	yes
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment?	yes
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or	yes

	information they receive regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation?	
115.361 (b)	**Staff and agency reporting duties**	
	Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws?	yes
115.361 (c)	**Staff and agency reporting duties**	
	Apart from reporting to designated supervisors or officials and designated State or local services agencies, are staff prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions?	yes
115.361 (d)	**Staff and agency reporting duties**	
	Are medical and mental health practitioners required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws?	yes
	Are medical and mental health practitioners required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services?	yes
115.361 (e)	**Staff and agency reporting duties**	
	Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office?	yes
	Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim’s parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified?	yes
	If the alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim’s caseworker instead of	yes

	the parents or legal guardians? (N/A if the alleged victim is not under the guardianship of the child welfare system.)	
	If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation?	yes
115.361 (f)	**Staff and agency reporting duties**	
	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
115.362 (a)	**Agency protection duties**	
	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
115.363 (a)	**Reporting to other confinement facilities**	
	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
	Does the head of the facility that received the allegation also notify the appropriate investigative agency?	yes
115.363 (b)	**Reporting to other confinement facilities**	
	Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation?	yes
115.363 (c)	**Reporting to other confinement facilities**	
	Does the agency document that it has provided such notification?	yes
115.363 (d)	**Reporting to other confinement facilities**	
	Does the facility head or agency office that receives such notification ensure that the allegation is investigated in	yes

	accordance with these standards?	
115.364 (a)	**Staff first responder duties**	
	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
	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
	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
	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
115.364 (b)	**Staff first responder duties**	
	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
115.365 (a)	**Coordinated response**	
	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
115.366 (a)	**Preservation of ability to protect residents from contact with abusers**	

	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
115.367 (a)	**Agency protection against retaliation**	
	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
	Has the agency designated which staff members or departments are charged with monitoring retaliation?	yes
115.367 (b)	**Agency protection against retaliation**	
	Does the agency employ multiple protection measures for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations, 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?	yes
115.367 (c)	**Agency protection against retaliation**	
	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
	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
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report	yes

	of sexual abuse, does the agency: Act promptly to remedy any such retaliation?	
	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
	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
	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
	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
	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
	Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need?	yes
115.367 (d)	**Agency protection against retaliation**	
	In the case of residents, does such monitoring also include periodic status checks?	yes
115.367 (e)	**Agency protection against retaliation**	
	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
115.368 (a)	**Post-allegation protective custody**	
	Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342?	yes

115.371 (a)	**Criminal and administrative agency investigations**	
	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 does not conduct any form of administrative or criminal investigations of sexual abuse or harassment. See 115.321(a).)	na
	Does the agency conduct such investigations for all allegations, including third party and anonymous reports? (N/A if the agency does not conduct any form of administrative or criminal investigations of sexual abuse or harassment. See 115.321(a).)	na
115.371 (b)	**Criminal and administrative agency investigations**	
	Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334?	yes
115.371 (c)	**Criminal and administrative agency investigations**	
	Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data?	yes
	Do investigators interview alleged victims, suspected perpetrators, and witnesses?	yes
	Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator?	yes
115.371 (d)	**Criminal and administrative agency investigations**	
	Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation?	yes
115.371 (e)	**Criminal and administrative agency investigations**	
	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
115.371	**Criminal and administrative agency investigations**	

(f)		
	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
	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
115.371 (g)	**Criminal and administrative agency investigations**	
	Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse?	yes
	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
115.371 (h)	**Criminal and administrative agency investigations**	
	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
115.371 (i)	**Criminal and administrative agency investigations**	
	Are all substantiated allegations of conduct that appears to be criminal referred for prosecution?	yes
115.371 (j)	**Criminal and administrative agency investigations**	
	Does the agency retain all written reports referenced in 115.371(g) and (h) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention?	yes
115.371 (k)	**Criminal and administrative agency investigations**	
	Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the facility or agency	yes

	does not provide a basis for terminating an investigation?	
115.371 (m)	**Criminal and administrative agency investigations**	
	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 115.321(a).)	yes
115.372 (a)	**Evidentiary standard for administrative investigations**	
	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
115.373 (a)	**Reporting to residents**	
	Following an investigation into a resident’s allegation of sexual abuse suffered in the facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded?	yes
115.373 (b)	**Reporting to residents**	
	If the agency did not conduct the investigation into a resident’s allegation of sexual abuse in an agency 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
115.373 (c)	**Reporting to residents**	
	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
	Following a resident’s allegation that a staff member has committed sexual abuse against the resident, unless the agency	yes

	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?	
	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
	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
115.373 (d)	**Reporting to residents**	
	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
	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
115.373 (e)	**Reporting to residents**	
	Does the agency document all such notifications or attempted notifications?	yes
115.376 (a)	**Disciplinary sanctions for staff**	
	Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies?	yes

115.376 (b)	**Disciplinary sanctions for staff**	
	Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse?	yes
115.376 (c)	**Disciplinary sanctions for staff**	
	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
115.376 (d)	**Disciplinary sanctions for staff**	
	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
	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
115.377 (a)	**Corrective action for contractors and volunteers**	
	Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents?	yes
	Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)?	yes
	Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies?	yes
115.377 (b)	**Corrective action for contractors and volunteers**	
	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

115.378 (a)	**Interventions and disciplinary sanctions for residents**	
	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, may residents be subject to disciplinary sanctions only pursuant to a formal disciplinary process?	yes
115.378 (b)	**Interventions and disciplinary sanctions for residents**	
	Are disciplinary 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
	In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible?	yes
115.378 (c)	**Interventions and disciplinary sanctions for residents**	
	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
115.378 (d)	**Interventions and disciplinary sanctions for residents**	
	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 offer the offending resident participation in such interventions?	yes

	If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education?	yes
115.378 (e)	**Interventions and disciplinary sanctions for residents**	
	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
115.378 (f)	**Interventions and disciplinary sanctions for residents**	
	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
115.378 (g)	**Interventions and disciplinary sanctions for 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
115.381 (a)	**Medical and mental health screenings; history of sexual abuse**	
	If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening?	yes
115.381 (b)	**Medical and mental health screenings; history of sexual abuse**	
	If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening?	yes
115.381 (c)	**Medical and mental health screenings; history of sexual abuse**	

	Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law?	yes
115.381 (d)	**Medical and mental health screenings; history of sexual abuse**	
	Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18?	yes
115.382 (a)	**Access to emergency medical and mental health services**	
	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
115.382 (b)	**Access to emergency medical and mental health services**	
	If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362?	yes
	Do staff first responders immediately notify the appropriate medical and mental health practitioners?	yes
115.382 (c)	**Access to emergency medical and mental health services**	
	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
115.382 (d)	**Access to emergency medical and mental health services**	
	Are treatment services provided to the victim without financial	yes

	cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?	
115.383 (a)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	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
115.383 (b)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	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
115.383 (c)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility provide such victims with medical and mental health services consistent with the community level of care?	yes
115.383 (d)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.)	na
115.383 (e)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	If pregnancy results from the conduct described in paragraph § 115.383(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.)	na
115.383 (f)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate?	yes
115.383 (g)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or	yes

	cooperates with any investigation arising out of the incident?	
115.383 (h)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	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
115.386 (a)	**Sexual abuse incident reviews**	
	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
115.386 (b)	**Sexual abuse incident reviews**	
	Does such review ordinarily occur within 30 days of the conclusion of the investigation?	yes
115.386 (c)	**Sexual abuse incident reviews**	
	Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners?	yes
115.386 (d)	**Sexual abuse incident reviews**	
	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
	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
	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
	Does the review team: Assess the adequacy of staffing levels in that area during different shifts?	yes

	Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff?	yes
	Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1)-(d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager?	yes
115.386 (e)	**Sexual abuse incident reviews**	
	Does the facility implement the recommendations for improvement, or document its reasons for not doing so?	yes
115.387 (a)	**Data collection**	
	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
115.387 (b)	**Data collection**	
	Does the agency aggregate the incident-based sexual abuse data at least annually?	yes
115.387 (c)	**Data collection**	
	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
115.387 (d)	**Data collection**	
	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
115.387 (e)	**Data collection**	
	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	na

	the confinement of its residents.)	
115.387 (f)	**Data collection**	
	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.)	na
115.388 (a)	**Data review for corrective action**	
	Does the agency review data collected and aggregated pursuant to § 115.387 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
	Does the agency review data collected and aggregated pursuant to § 115.387 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
	Does the agency review data collected and aggregated pursuant to § 115.387 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
115.388 (b)	**Data review for corrective action**	
	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
115.388 (c)	**Data review for corrective action**	
	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
115.388 (d)	**Data review for corrective action**	
	Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when	yes

	publication would present a clear and specific threat to the safety and security of a facility?	
115.389 (a)	**Data storage, publication, and destruction**	
	Does the agency ensure that data collected pursuant to § 115.387 are securely retained?	yes
115.389 (b)	**Data storage, publication, and destruction**	
	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
115.389 (c)	**Data storage, publication, and destruction**	
	Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available?	yes
115.389 (d)	**Data storage, publication, and destruction**	
	Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise?	yes
115.401 (a)	**Frequency and scope of audits**	
	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
115.401 (b)	**Frequency and scope of audits**	
	Is this the first year of the current audit cycle? (Note: a “no” response does not impact overall compliance with this standard.)	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

	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.)	no
115.401 (h)	**Frequency and scope of audits**	
	Did the auditor have access to, and the ability to observe, all areas of the audited facility?	yes
115.401 (i)	**Frequency and scope of audits**	
	Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)?	yes
115.401 (m)	**Frequency and scope of audits**	
	Was the auditor permitted to conduct private interviews with inmates, residents, and detainees?	yes
115.401 (n)	**Frequency and scope of audits**	
	Were inmates, residents, and detainees permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel?	yes
115.403 (f)	**Audit contents and findings**	
	The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports. The review period is for prior audits completed during the past three years PRECEDING THIS 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, there has never been a Final Audit Report issued.)	yes