PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: February 9th, 2017

Auditor Information			
Auditor name: Jerome K. Williams			
Address: 17921 Maxa Dr, Manor, Texas 78653			
Email: jkwmss@netzero.net			
Telephone number: 512-636-8137			
Date of facility visit: June 29th-July 1st, 2016			
Facility Information			
Facility name: Shamar Hope Haven Residential Treatment Center			
Facility physical address: 2013 Wheeler St, Houston, Texas 77004			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 713-942-8822			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☒ Private not for profit		
Facility type:	☐ Correctional	☐ Detention	☒ Other
Name of facility's Chief Executive Officer: Sharon Evans, Executive Director			
Number of staff assigned to the facility in the last 12 months: 32			
Designed facility capacity: 22			
Current population of facility: 13			
Facility security levels/inmate custody levels: Non-secure			
Age range of the population: 10-17 years of age			
Name of PREA Compliance Manager: N/A		**Title:** Click here to enter text.	
Email address: Click here to enter text.		**Telephone number:** Click here to enter text.	
Agency Information			
Name of agency: Shamar Hope Haven Residential Treatment Center			
Governing authority or parent agency: *(if applicable)* N/A			
Physical address: 2013 Wheeler St, Houston, Texas 77004			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 713-942-8822			
Agency Chief Executive Officer			
Name: Sharon Evans		**Title:** Executive Director	
Email address: evanservan@aol.com		**Telephone number:** 713-842-8822	
Agency-Wide PREA Coordinator			
Name: Sharon Evans		**Title:** Executive Director	
Email address: evanservan@aol.com		**Telephone number:** 713-842-8822	

AUDIT FINDINGS

NARRATIVE

The PREA Audit was conducted on June 29th to July 1st, 2016 at the Shamar Hope Haven Residential Treatment Center in Houston, Texas, a non-secure, Title IV E, not for profit facility. The audit was conducted by the certified PREA Auditor for Juvenile & Adult Facilities, Jerome K. Williams. The agency did provide pictures displaying the PREA Audit Notices on blue paper throughout the 2 houses and in the administrative office during the pre-audit process.

Following the entrance meeting a thorough tour of the facility was provided by the Executive Director/PREA Coordinator. Continuing on this first day of the audit a comprehensive listing of the youth and staff was requested and provided for the interviews with the necessary adjustments being made to compensate for schedule changes, etc. During the tour random interviews were conducted of youth and staff to ascertain their knowledge of the PREA Standards, reporting procedures, services available and their reporting responsibilities. A total of 11 youths were interviewed during this onsite visit. The youth interviewed acknowledged receiving some PREA training, written information (i.e. resident handbook, hotline numbers, Break the Silence posters, and brochures) and were informed of related policies that outline the facility's zero tolerance towards sexual abuse, sexual harassment and their right to be free from retaliation for reporting sexual abuse and sexual harassment allegations.

A total of 7 specialized staff members were interviewed comprising of the Executive Director/PREA Coordinator, the Director of Programs, the Psychologist, the Social Worker, the Direct Care Supervisor, a Shift Supervisor, and the Intake staff interviewed. A total of 10 random staff members were also interviewed. The staff interviewed were knowledgeable of their responsibilities in reporting sexual abuse and sexual harassment allegations, staff negligence and the steps required in monitoring for staff and or youth for retaliation. When questioned about evidence preservation, all of the staff responses reflected their knowledge of the agency's policy on evidence collection but not as knowledgeable of their first responder duties. There were no SAFE and or SANE personnel at this facility but they are available at the Texas Children's Hospital located in Houston, Texas. The hospital personnel indicated that they are aware of the SANE protocol to be implemented if the facility were bring a youth there for a SANE examination and they also provided training to all of Shamar Hope Haven's staff on their first responder responsibilities and duties.

The auditor observed some blind spots in the facility, reviewed the staff placement for monitoring and supervision, observed supervisory presence on each shift, the youth's sleeping area and then toured the facility's administrative area. There are 2 Houses (one on Wheeler St and the other on Truxillo St) with only the Truxillo House being utilized due to the low population. A review all of the required documentation to assist in determining this facility's PREA standard compliance was then conducted at the administrative office. Upon completion of the onsite audit an exit meeting was held with the Executive Director/PREA Coordinator, the Director of Programs, and the Administrative Assistant. The Executive Director/PREA Coordinator was provided with a general overview of the audit process initiated, audit highlights, which included a synopsis of the file and documentation review, the staff and youth interviews and the observation made during the facility tour. During the debriefing the auditor informed the Executive Director/PREA Coordinator that in the event there were standards not met that he would work closely to assist her through a corrective action plan process towards accomplishing them within the 180 day corrective action period, if applicable, towards 100% PREA compliance. She was also informed that all of the corrective action documentation required to demonstrate compliance with a "did not meet" standard is to be uploaded on a USB Drive and sent to the auditor within the agreed upon timeframe within the corrective action period. A period of institutionalization of any practice or protocol would also be required during this corrective action period, if applicable. Furthermore, after the documentation submission and a review of the required corrective action items provided along with the institutionalization of any applicable practice and protocol being achieved, then the agency will receive a Final Report. This Final Report will be required to be posted on the agency's website once issued.

This report is considered to be the Final PREA Audit Report.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Shamar Hope Haven Residential Treatment Center is a 22 bed, combined in two Houses, non-secure, Title IV E residential treatment facility licensed by the Texas Department of Family and Protective Services located in Houston, Texas with the mission to provide private treatment for youth affected by chemical dependency. The Inpatient program is designed to provide rehabilitation services to chemically dependent youths who require widely varying levels of structure and guided approaches to recovery. They provided the state of the art technology in the treatment of behavioral health and substance use disorders. The agency staff is dedicated to providing research based, culturally and developmentally appropriate therapeutic modalities to their clientele and their families. They are committed to excellence in their mandated programs of providing the youth the skills necessary to live a healthy and drug free lifestyle in a safe, sanitary and nurturing environment.

The Shamar Hope Haven Residential Treatment Center also provides the opportunity for each youth to achieve his personal goals by providing specialized programs and trained professionals to provide the required treatment for each individual youth. Shamar Hope Haven Residential Treatment Programs represents the first step in a youth's ongoing treatment plan. While in the residential treatment program the youths begin the healing process by participating in a number of training sessions, groups and individual counseling session such as Chemical Dependency Counseling and Education, HIV Education, Testing and Counseling, Anger Management, Gang Resistance Education and Training, Recreation and Fitness Activities, Social and Life Skills Activities, GED Preparation and Tutorials, Community Service and Vocational training.

On the day of the audit there were 13 youths assigned to the facility in totality residing at the Truxillo House. The facility provides professional custodial care, crisis intervention counseling, education, and other services through counselor, clinical staff, and the licensed psychologist that provide a wide variety of treatment services grounded in evidence-based principles and cognitive behavioral interventions, including relationship-based and strength based services. The agency also provides individual, family and group counseling, substance abuse treatment, psychological evaluations, aggressive management sessions, case management services; the youth participate in community service, life skills training, drug education, anti-victimization and social skills for daily living. The youth assigned to this facility attend Yates and or Cullen High school here in Houston, Texas.

The agency has 2 houses (Wheeler and Truxillo) with both comprising a floor plan of a kitchen area, dining/dayroom area, with 22 combined, bunkbed (9 beds at Wheeler House and 13 beds at Truxillo House) being located upstairs in each House;). The administrative building has 2 offices, a receptionist area, an upstairs classroom (which was not in usage due to the low population), a kitchen utilized to storing foodstuff and supplies for the two houses. The shower and restroom areas in each House are private and only one youth at a time utilizes it for hygiene and showers usage, having a door for privacy. There are no cameras in this facility. The shower routines are conducted by male staff only since this is an all-male youth facility and the auditor was informed by the staff and youth that staff of the opposite gender do announce their presence when entering the youth sleeping area upstairs (although this practice was not observed during the onsite visit). The facility was operating safely, observably clean and the staff to youth ratio and interaction was appropriate during the days of this onsite audit visit.

SUMMARY OF AUDIT FINDINGS

The Shamar Hope Haven Residential Treatment Center is a non-secure, Title IV-E facility which has a separate administrative building, two youth residential (2) Houses, they both have a recreation area in the backyard for basketball, they both have their own kitchen for meal preparation, a dayroom/multipurpose rooms, a dining area, a lounge and a staff office. The sleeping and restrooms area of this facility was clean, maintained, was staffed accordingly and operating orderly during the days of this onsite visit. There were no Zero Tolerance and or End the Silence posters displayed having the hotline number on them in either house, the PREA Audit Notices were displayed in each house on blue colored paper to be easily distinguished, and observably, there was an appropriate staff to youth ratios of 1:5 during waking hours and 1:15 during sleeping hours, including 1:1 ratio for close observation if needed. The shift supervisors were visible in Truxillo House, especially when the youth were involved in off campus activities i.e. going to the local gym to participate in FIT training and weightlifting. There are no cameras installed in this facility but it was recommended that the installation of cameras, if funding becomes available, be placed in areas to cover any and all blind spots i.e. utility closets, hallways, dining area, backyard, etc. in, throughout each house and also in administrative offices to further augment the staff's supervision and monitoring of the youth. The 10 residents interviewed appeared to be informed of their rights to be free from sexual abuse and sexual harassment, how to report such incidents and their rights to be free from retaliation if they report a sexual abuse and sexual harassment allegation. They were not as knowledgeable of any outside advocate agency that would provide emotional support and crisis counseling services to a victim of sexual abuse if needed. It was noted that the youth's knowledge of PREA was limited after the initial Intake since the focus was more on informing the youth, which the majority of them were placed there by the Department of Family and Protective Services, about how to report an abuse, neglect or exploitation allegations. It was recommended to the Director of Programs that a more comprehensive education on PREA need to be provided to the youth within 10 days of Intake. It was also recommended that they show and discussed with the youth the Safeguarding Your Sexual Safety DVD or similar video during the orientation phase to enhance their knowledge within 10 days of Intake while providing all of the youth with a hard copy of the newly acquired PREA-related brochure and information during this time. The eight (8) specialized staff members and the ten (10) random staff members interviewed were knowledgeable regarding the facility's reporting procedures but did not thoroughly know of the facility's draft PREA policy. They were not able to adequately articulate the facility's protocol for collecting evidence and they were limited in their knowledge of their first responder's duties especially regarding informing the alleged victim or perpetrator not to eat, shower, drink anything, etc. if they were abused or the abuser. But the staff was knowledgeable of the procedures to be followed if and when they become knowledgeable of, suspect or are notified of a sexual abuse allegation or incident. A review of the youth, staff training and personnel files did contain most of the required documentation in accordance to the PREA standards. This documentation reviewed also provided more insight as to their preparation for this audit and their practice towards preventing, detecting and responding to sexual abuse, sexual harassment and staff neglect policy violation. It was also noted that many of the random staff did not know who or what entity was responsible for conducting administrative and or criminal sexual abuse investigations and retraining/education on these entities was strongly recommended. During the past 12 months the facility reported that there were zero administrative and zero criminal investigative cases, including zero grievances alleging sexual abuse and sexual harassment in this facility. This facility is licensed by the Department of Family and Protective Services, a division of the Department of Health and Human Services, whereas they have less than 51% of juvenile justice youth in their population but the Executive Director/PREA Coordinator felt that by becoming compliant with the PREA standards that this would only enhance their sexual safety practices and further demonstrate to the juvenile justice agencies, whom they contract with, of their intentions towards keeping the youth sexually safe while in their facilities. Of the 41 standards this facility was found to have "met" 7 of the standards, "did not meet" 32 of the standards and had 2 "not applicable" at the conclusion of this onsite visit. A corrective action plan was developed in collaboration with the Executive Director/PREA Coordinator and she did receive the Interim Report within 30 days of last day of the onsite visit, she did have 180 days to provide the required documentation for each unmet standard and to institutionalize any required practices and protocols with demonstrative evidence in order to become fully compliant with the PREA standards thereby receiving a Final Report certifying the same.

The facility's Executive Director/PREA Coordinator did provide the required documentation as part of the corrective action plan for the 32 "did not meet" standards during this corrective action period of 180 days and after a review of what has been submitted to this auditor, it has been determined that this facility has demonstrated full compliance in all of the 41 standards. The facility has been instructed to post this Final Report on the agency's website within 90 days of her receipt of this report.

Number of standards exceeded: 0

Number of standards met: 39

Number of standards not met: 0

Number of standards not applicable: 2

Standard 115.311 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance Policy, Organizational Chart, Agency Website and Interview with the Executive Director/PREA Coordinator.

Findings: A. The Shamar Hope Haven Residential Treatment Center has a Zero Tolerance policy towards preventing, detecting and responding to all forms of sexual abuse and sexual harassment. The policy includes a description of how the agency responds to allegations of sexual abuse and sexual harassment as well as how they will go about reducing and preventing these incidents. This Zero Tolerance policy also has definitions that pertained to PREA and it does have sanctions for youth, staff, volunteers and contractors who participate in the listed prohibited behaviors of sexual abuse, sexual harassment and policy violation. The facility's Zero Tolerance policy was not posted on the agency's web site for review by this auditor since it is still in revision. B. The facility's Executive Director acts as the dedicated PREA Coordinator who in turn reports to her Board of Director, as indicated by the organizational chart provided reflecting this position and she did indicate that she has sufficient time to fulfill her PREA responsibilities during her interview.

Corrective Action Findings: The facility must provide to the auditor a copy of their organizational chart and a copy of the finalized Zero Tolerance policy as evidence, and then have them posted on their website in order to be in compliance with this standard.

Resolution: The facility's Executive Director/PREA Coordinator did provide to the auditor a copy of her organizational chart and a copy of the finalized Zero Tolerance policy as evidence, including having it posted on the agency's website, therefore demonstrating compliance with this standard.

Standard 115.312 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance Policy, and Interview with the Executive Director/PREA Coordinator.

Findings: The Shamar Hope Haven Residential Treatment Center does not enter into contracts with other contracting residential facilities for their youth. A. There were zero contracts of residential providers to be reviewed during the audit process because of this. The facility's Executive Director/PREA Coordinator did indicate that, if it were applicable, the PREA language would be included in each contractor's contract and that they would be reviewed prior to the annual contract renewal period. B. There is no monitoring necessary for PREA compliance with other entities since they do not contract out services with other residential providers, thus making this standard not applicable to this agency.

Corrective Action Findings: Not applicable
Resolution: None

Standard 115.313 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policies and Evidence to be reviewed: Draft Zero Tolerance Policy, Staffing Plan Assessment and Staffing Plan, Memorandums if applicable, Annual Board Meeting minutes, Unannounced Rounds log/documentation, Staffing and Youth Roster, Video Monitoring documentation if applicable, Executive Director/PREA Coordinator and Intermediate and Higher Level Staff Interviews.

Findings: The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy does require the supervision and monitoring of the youth while in the facility (Houses). A. The daily average number of youth in this facility is 18 and the staffing plan is predicated on the average daily population total of 22 youths. B and C. The facility did provide written documentation during the audit that demonstrated compliance with this standard and at no time has the facility deviated from their staff–to-youth ratio of 1:5 during waking hours and 1:15 during sleeping hours. D. The facility did not provide written evidence of their staffing plan or indicated that the facility's Executive Director/PREA Coordinator reviews the staffing plan annually with her Board of Directors including their commitment to adhere to this plan. For fiscal year 2015-16, the Executive Director/PREA Coordinator did state that the proposed plan does not include the hiring of any full time equivalents (FTEs) since they are already exceeding the staff-to-youth ratio of 1:8 during waking hours and 1:16 during sleeping hours as required by the PREA standards as of October 1st, of 2017. E. The facility's PREA Coordinator did not provide written evidence that their higher level supervisors conduct unannounced rounds on all shifts though the she did indicate that this practice does occurs which was also corroborated by the Director of Programs but just was not being documented. The facility's finalized Zero Tolerance policy does indicate that disciplinary action will occur if a staff alert other staff of these unannounced rounds and during the random staff interviews they did indicate their awareness of this policy. During the visit to the Truxillo House I did not observed the opposite gender staff utilized the knock and announcement method to announce her presence before entering that house and was informed that if they do go upstairs where showering, the restroom and the changing of clothing by the youth occurs that an announcement would be made. Because they have two private restrooms inclusive of a shower in these houses (Wheeler and Truxillo) with private doors, being observant by the opposite gender is not a problem in these facilities. Both the staff and youth confirmed that this knock and announcement practice of the opposite gender was occurring in this all-male youth facility.

Corrective Action Findings: The facility must provide a copy of their staffing plan, a memorandum as evidence that the staffing plan is reviewed annually with the Executive Director/PREA Coordinator and her Board of Directors and written documentation that unannounced round are being made on all shifts at least once a month by intermediate and higher level staff in order to be in compliance with this standard.

Resolution: The facility's Executive Director/PREA Coordinator did provide a copy of their staffing plan, she did provide a memorandum as evidence that the staffing plan is reviewed annually with her Board of Directors and did provide a memorandum demonstrating that the unannounced rounds have been made on all shifts monthly by her intermediate and higher level staff for the months of July, August, September, October, November and December of 2016, therefore demonstrating compliance with this standard.

Standard 115.315 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance Policy, Search Logs if applicable, any PREA Training Curriculums, and the Random Staff and Youth Interviews.

Findings: A and B. The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy does prohibit cross gender viewing during restroom, changing clothes and shower routines and prohibits cross gender pat, visual body and strip searches absence exigent circumstances. There were no cross gender pat, visual or strip searches conducted by medical personnel and or for an exigent circumstance during the last 12 months in this facility as indicated by the Executive Director/PREA Coordinator. C and E. A review of the search logs as well as the staff and youth interviews verified that this prohibited practice does not exist including searching or physically examining a Transgender or Intersex youth to determine their genitalia. This is an all-male facility and they did not have any Transgender or Intersex youth in their population. The facility's Executive Director/PREA Coordinator indicated that she would provide the auditor with a memorandum as evidence that further states the prohibition of this practice. D. The youth interviewed were able to definitively articulate that the female staff do knock and announce their presence before entering their upstairs' sleeping areas, that they are able to shower, dress and change clothing without being observed by the opposite gender and that at no time have a staff member of the opposite gender pat searched their person. The facility did not provide a copy of the training curriculum on cross gender pat searches but the Executive Director/PREA Coordinator did state that all searches would be conducted professionally and in a respectful manner consistent with the security needs of the facility. The staff definitively articulated that professionalism occurs at all times during searches during their interviews though none were observed during the facility tour or during the onsite visit. F. The facility did not provide written evidence demonstrating that the staff were trained in cross gender pat searches and searching of Transgender and Intersex youth in the event an exigent circumstance arises, which is a PREA requirement.

Corrective Action Findings: The facility must provide evidence in the form of a training curriculum and signed staff training rosters that the staff has all been trained in cross gender pat searches and searches of Transgender and Intersex youth in the event an exigent circumstance arises. The auditor recommended that this training be obtained from the PREA Resource Center and or the National Institute of Correction's website for usage. The facility must also provide written evidence in the form of a memorandum that there have been no cross gender pat searches conducted in the last 12 months in order to be in compliance with this standard.

Resolution: The facility's Executive Director/PREA Coordinator did provide evidence in the form of a training curriculum and copies of signed staff training rosters reflecting that the staff have all been trained in cross gender pat searches and searches of Transgender and Intersex youth in the event an exigent circumstance arises. She also provided written evidence in the form of a memorandum that there have been no cross gender pat searches conducted in the last 12 months and that this practice is prohibited, therefore demonstrating compliance with this standard.

Standard 115.316 Residents with disabilities and residents who are limited English proficient

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance Policy, Intake and Orientation Documentation, Resident Orientation Handbook if applicable, PREA Posters, Shamar Hope Haven Policy and Procedure Manual, Translation and Interpreting Contract if applicable, Harris

County Independent School District Agreements, Random Staff and Youth Interviews.

Findings: A. The Shamar Hope Haven Residential Treatment Center did provide to the auditor a copy of their Zero Tolerance policy but did not provided any written PREA material in Spanish i.e. handbook, brochures, etc. which the Intake staff would provide to the youth during their Intake and also during Orientation. B. The facility Executive Director/PREA Coordinator did indicate that they do not utilize their staff for interpreting but they do contract with an Interpreter and that they can access interpreting services for the youth through the Harris County Independent School District including services for those youth who may be deaf, speech impaired, limited in English proficiency, blind and or low vision, or who are psychiatric or intellectually disabled. The facility did provide the auditor with the name of the contracting staff who would be utilized as the interpreter for Spanish speaking youth, though they did not have any in their population. The facility did not identified any youth in their care and custody during this onsite audit to be interviewed as being limited in English Proficiency or needing other interpreting services in the last 12 months. C. The facility's Executive Director/PREA Coordinator did indicate that they do not utilizing youth interpreters, youth assistants or youth readers for reporting sexual abuse and sexual harassment allegation and that this practice is prohibited in this facility's by policy. The facility's Intake staff did not have written PREA-related information to provide to a youth who would enter their facility in Spanish during the onsite visit.

Corrective Action Findings: The facility must provide written evidence that all of their PREA related information has been translated into Spanish, including information that it is provided to the youth during intake and that this information is displayed throughout each House in order to achieve compliance in this standard.

Resolution: The facility's Executive Director/PREA Coordinator did provide written evidence i.e. brochures, posters, etc. that all of their PREA related information have been translated into Spanish, including information that it is provided to the youth during intake, and did provide pictures showing that this information has been displayed throughout each House, therefore demonstrating compliance in this standard.

Standard 115.317 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance Policy, Shamar Hope Haven Policy and Procedure Manual, Volunteer and Contractor Policy and Agreements if applicable, Criminal Records and Child Abuse Registry Check Documentation, Employment Application and Self Disclosure Affidavit if applicable, Training Records and Interview with the Executive Director/PREA Coordinator.

Findings: A. The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy does consider any incident of sexual abuse and sexual harassment in determining whether to hire, promote or enlist the services of contractors who have contact with the youth. The facility's Zero Tolerance policy does state that providing false information will be grounds for termination for omitting information of misconduct. It also provides that a former employee's misconduct will be provided to another agency for substantiated findings of sexual abuse and sexual harassment. B. For volunteers, their services will be terminated and for contractors the finding will be reported to their licensing authority. An interview with the Executive Director/PREA Coordinator revealed that the agency does conduct criminal background and child abuse registry checks prior to hiring and promotions. A random review of personnel files corroborated this assertion. C, D and E. The facility did provide written evidence showing that they do conduct background checks and child abuse registry checks on all current employees, which is also performed every five years even and was evident in the random personnel files reviewed. F. The facility did not provide written evidence on self-reporting requirements of their employees, although their policy does reference omissions regarding misconduct which shall be grounds for termination. The Executive Director/PREA Coordinator did provide a sample reference check form reflecting that all staff, volunteers and contractors have had their background checks completed. The facility's personnel files upon review did reflect documentation supporting that 100% of their staff; volunteers and contractors have had background and child abuse registry checks performed during the last 12 months. There was 1 new hire during this reporting period and zero service contractors and zero volunteers whereas background and child abuse registry checks were conducted and evident in their personnel files.

Corrective Action Findings: The facility must provide a copy of the background checks and child abuse registry checks on their employees, must include in their Zero Tolerance policy and incorporate in the employment application process the self- disclosure statement that "an employee must self-report misconduct" at all times in order to be compliant with this standard.

Resolution: The facility's Executive Director/PREA Coordinator did provide a copy of the background checks and child abuse registry checks of her employees, she did include in their Zero Tolerance policy and in the employment application process the requirement that "an employee must self-report misconduct" at al times and she did provide signed self-disclosure statements from all her employed staff, to be performed annually, therefore demonstrating compliance with this standard

Standard 115.318 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance Policy, Facility Onsite Visit, Number of Cameras and their location if applicable, Facility Schematics of the Houses and the Administrative building, and interview with the Executive Director/PREA Coordinator.

Findings: A. The Shamar Hope Haven Residential Treatment Center facility's Executive Director/PREA Coordinator did indicate during her interview that there have not been any modifications or any renovations made in the Houses as of August 20, of 2012 and that they currently have zero cameras in the two Houses and in the administrative building to augment the staff's supervision and monitoring of the youth. B. It was recommended by the auditor that if funding becomes available that adding cameras throughout the facility would be a "best correctional practice" to augment the staff's supervision and monitoring of the youth to prevent, detect and respond to allegations of sexual abuse and sexual harassment. This standard is not applicable to this agency.

Corrective Action Findings: Not applicable
Resolution: None

Standard 115.321 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance Policy, Memorandum from Houston Police Department if applicable, Texas Children's Hospital in Houston, any Child Advocacy Center and or Rape Crisis Center's Memorandum of Understandings if applicable and interview with the facility's Executive Director/PREA Coordinator.

Findings: A. The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy does outlines the protocol for conducting

investigations of sexual abuse and sexual harassment as well as requesting information from the respective investigative entities on the progress of each investigation. B. The facility's Executive Director/PREA Coordinator did state that the Department of Family and Protective Services (DFPS) and the Houston Police Department do follow the National Protocol for Sexual Assault Medical Forensic Examinations, Adult/Adolescents 2013 for obtaining usable evidence for administrative and criminal investigations. The Department of Family and Protective Services is the agency responsible for conducting administrative investigations and the Houston Police Department is the agency responsible for conducting criminal investigations of sexual abuse. C. The Texas Children's Hospital in Houston, Texas is the hospital where a youth would receive emergency medical care including where they would be taken by Houston Police Department in the event a forensic examination (SANE) for sexual abuse incident is required. D. The facility did not provide evidence in the form of a Memorandum of Agreement that the youth have will have access to obtain emotional support and crisis counseling services from a local Rape Crisis Center or an Advocacy Center, if they become a sexual abuse victim and or when needed. The facility's Executive Director/PREA Coordinator did state that in the last 12 months there have been zero SANE examinations required since there have been no sexual abuse victims. E. The facility's Executive Director/PREA Coordinator did indicate that they do not have a qualified mental health staff member on duty to serve as an advocate for a victim of sexual abuse but did not indicate that the hospital would provide these services. F. The facility's Executive Director/PREA Coordinator did state that she would provide a memorandum as evidence requesting the Houston Police Department to follow the requirements of the National Protocol for Sexual Assault Medical Forensic Examinations, Adult/Adolescents 2013 for obtaining usable evidence for criminal investigations in the event of a sexual abuse investigation.

Corrective Action Findings: The facility must provide evidence in the form of a memorandum from the Houston Police Department requesting that they agree to follow the National Protocol for Sexual Assault Medical Forensic Examinations, that they will seek to enter into a Memorandum of Understanding or Agreement with a local Rape Crisis Center and or an Advocacy Center for the provision of emotional support and crisis counseling for a victim of sexual abuse in order to be in compliance with this standard.

Resolution: The facility's Executive Director/PREA Coordinator did provide evidence in the form of a memorandum from the Houston Police Department attesting that they do agree to follow the National Protocol for Sexual Assault Medical Forensic Examinations in the event of a sexual abuse investigation, and she did provide a copy of the Memorandum of Understanding from the Sexual Assault Resource Center (SARC) for the provision of emotional support and crisis counseling for a victim of sexual abuse, therefore demonstrating compliance with this standard

Standard 115.322 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance Policy, Incident Reports, Copies of Investigative Cases if applicable, the Agency Website, and the Investigator's Interviews if applicable.

Findings: A and B. The .The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy does require that all allegations of sexual abuse and sexual harassment are to be reported to the Executive Director. It further describes that the Department of Family and Protective Services (DFPS) Investigators are charged with conducting the administrative investigations and the Houston Police Department will conduct all criminal investigations. The facility's Executive Director/PREA Coordinator did provide the auditor with a sample copy of their Incident Report that is shared with the Department of Family Protective Services and the Houston Police Department in the event of a sexual abuse allegation resulting in an administrative and or criminal investigation, if applicable. The Shamar Hope Haven Residential Treatment Center did report that there were zero allegations during the last 12 months for sexual abuse resulting in zero criminal investigations and zero administrative investigations. The facility have not posted their Zero Tolerance policy as of the onsite visit that outlines the investigative process on their website for review, which is required by this standard.

Corrective Action Findings: The facility must provide a memorandum stating that there were zero allegations of sexual abuse and sexual harassment in the last 12 months, a copy of their Zero Tolerance policy that describes the investigative process for the Department of Family and Protective Services and the Houston Police Department for sexual abuse and sexual harassment allegations that has been posted on their

website, in order to demonstrate compliance with this standard.

Resolution: The facility's Executive Director/PREA Coordinatot did provide a memorandum stating that there were zero allegations of sexual abuse and sexual harassment in the last 12 months, and did post their Zero Tolerance policy that describes the investigative process for the Department of Family and Protective Services and the Houston Police Department for sexual abuse and sexual harassment allegations on their website, which was reviewed by this auditor, therefore demonstrating compliance with this standard

Standard 115.331 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance Policy, PREA-related Training Curriculums, Search Logs if applicable, Staff Signed Training Rosters, Training Certificates, and Random Staff Interviews.

Findings: A. The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy does require that the facility provide PREA related training to all its employees who may have contact with youth annually. The Executive Director/PREA Coordinator did provide written evidence of the various PREA training curriculus utilized wherein their staff was trained but not on LGBTI, communication boundaries, nor on cross gender pat search training. During the second day of onsite visit it was observed that the facility's Executive Director/PREA Coordinator was conducting PREA training for all of the direct care staff on cross gender pat down search training. B. The Executive Director/PREA Coordinator did indicate that their PREA Refresher training and PREA training will occur every year. C. The Executive Director/PREA Coordinator did indicate that the number of facility staff trained during the last 12 months were 32 or 100% and she did provide signed training rosters and certificates of the same. During the random staff interviews they were able to articulate the required elements as found in 115.331(a) (1-11) and115.331(b) as being met through the new hire orientation training and through on the job training sessions that occur quarterly (refresher training). The staff seemed versed and trained in the areas of PREA, their reporting duties, but were not as knowledgeable regarding all of their first responder responsibilities and what individuals and or entity would conduct the administrative and criminal investigations, based on the interviews. D. The facility's Executive Director/PREA Coordinator did provide written copies of the trainee's signed rosters and certificates with the course title and descriptions for each PREA related training class for the auditor's review. The Executive Director/PREA Coordinator did indicate during the onsite visit that she would be providing cross gender pat search training to her staff on June 30th at 9am.

Corrective Action Findings: The facility must provide copies of the signed training roster as evidence that all of the direct care staff (security staff) has been trained in cross gender pat search that was conducted on June 30th, 2016 and that the staff have been re-educated on what their first responder's duties including what entites would conduct the administrative and or criminal investigations of sexual abuse, in order to become compliance in this standard.

Resolution: The facility's Executive Director/PREA Coordinator did provide copies of the signed training roster as evidence that all of the direct care staff (security staff) have been trained in cross gender pat search that was conducted on June 30th, 2016 and that the staff have been re-educated on their first responder's duties i.e. informing the victim/perpetrator not to eat, drink, change clothing, etc, and what entites will conduct the administrative and or criminal investigations of sexual abuse, therefore demonstrating compliance in this standard.

Standard 115.332 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance Policy, Volunteer and Contractor's PREA-related Training Curriculum, Training Roster and or Certificates, and Volunteer and Contractor Interviews if applicable.

Findings: A. The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy does require that all volunteers and contractors who have direct access to youth are notified and are to be trained on understanding their reporting responsibilities regarding PREA. B. The facility did not provide written evidence of the PREA curriculum utilized to train volunteers since they have not had any volunteers in the last 12 months but did provide a signed training rosters and certificates of training provided to the three (3) contractors. C. The facility's Executive Director/PREA Coordinator did indicate on the PREA Questionnaire that the number of volunteers trained in PREA was zero, and that the number of contractors trained in PREA during the last 12 months were three (3), thus demonstrating compliance with this standard.

Corrective Action Findings: None
Resolution: Not applicable

Standard 115.333 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance Policy, Shamar Hope Haven Policy and Procedure Manual, any and all PREA related Video, Brochures, etc., Number of Admitted and Educated Youth Documentation, any and all Outside Interpreting Providers, Harris County Independent School District Agreements, Retaliation and Monitoring Log if applicable, and Random Staff and Youth Interviews.

Findings: A. The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy and practice does require that the youth be provided with an Orientation packet of information in English (though they did not have Spanish version) upon Intake regarding the rules and their rights. It was ascertained that the youth have not watched the Safeguarding Your Sexual Safety PREA video or other sexual safety mediums as part of the comprehensive education during orientation, but have been given PREA brochures and other information i.e. hotline number during orientation. It was also ascertained during the random staff and youth interviews that they do have 24 hour unimpeded phone access, to report an allegation of sexual abuse and sexual harassment. The facility's Zero Tolerance policy does indicate that the PREA orientation information is provided to the youth in an age appropriate manner as demonstrated in the PREA materials reviewed by the auditor. A review of the youth files by this auditor reflected notations of the date, time of the youth's intake and when this information was provided which is documented in the youth's file. B. Though the comprehensive PREA education must occur for the youths within 10 days of their Intake the facility could not provide documentation to demonstrate that it has occurred. C. The facility has admitted and educated 75 youth from the 75 youth who appeared at Intake during the last 12 months. D and E. The facility did not provide a written evidence demonstrating that Harris County Independent School District would provide services to those youth who are hearing, vision impaired, psychiatric and disabled but did indicate that the Harris County Independent School District will provide assistance for those youth who are intellectually, psychiatric disabled and limited in English proficiency. F. During the facility tour and interviews with some random youths, they acknowledged that they did not receive a PREA brochure during the Intake, was read some PREA information to them during the Intake/Orientation process and did acknowledge that they have not watched the Safeguarding Your Sexual Safety PREA video or any other PREA related DVD as part of the comprehensive education process. The Executive Director/PREA coordinator did indicate that they will begin to show this video to all current and subsequent youth during the Orientation process and obtain signed rosters of the same within 10

days of their Intake. The youth interviewed were able to articulate their knowledge regarding PREA, reporting requirements and of their freedom from being retaliated against. The facility's Executive Director/PREA Coordinator did indicate that the Zero Tolerance policy and other PREA related posters, brochures, etc. will have the hotline numbers for reporting incidents of sexual abuse and sexual harassment and that it will be prominently displayed throughout the Houses and in the administrative building.

Corrective Action Findings: The facility must provide signed training rosters that all current and future youth have reviewed the Safeguarding Your Sexual Safety DVD or other PREA-related video within 10 days of Intake, that copies of all PREA related information must be translated into Spanish and a copy of the Memorandum of Understanding/Agreement indicating that the Harris County Independent School District will provide assistance to youth who are hearing impaired, vision impaired, intellectually, psychiatric disabled and limited in English proficiency in order to be in compliance with this standard.

Resolution: The facility's Executive Director/PREA Coordinator did provide signed training rosters that all current and future youth have reviewed the Safeguarding Your Sexual Safety DVD within 10 days of Intake as part of the comprehensive education, she did provide copies of all PREA related information that has been translated into Spanish and did provide a copy of the Memorandum of Understanding indicating that the Harris County Independent School District will provide assistance to youth who are hearing impaired, vision impaired, intellectually, psychiatric disabled and limited in English proficiency, therefore demonstrating compliance with this standard.

Standard 115.334 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance Policy, Memorandum from the Department of Family and Protective Services and the Houston Police Department.

Findings: A. The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy does indicate that the Department of Family and Protective Services is the entity that will conduct their administrative investigations and that the Houston Police Department is the outside law enforcement entity who will conduct their criminal investigations for sexual abuse and sexual harassment allegations. B. The Shamar Hope Haven Residential Treatment Center does not have any internal investigator but if they did they indicated that they would have received the specialized interview training including Miranda and Garrity warning, evidence collection, etc. to assist them in conducting sexual abuse and sexual harassment investigations. All sexual abuse criminal allegations will be referred to the Houston Police Department as the outside law enforcement for investigation. C. The Executive Director/PREA Coordinator did indicate that she would provide a memorandum from Department of Family and Protective Services indicating that their Investigators have received the required specialized interviewing training when conducting sexual abuse investigations.

Corrective Action Findings: The facility will provide a memorandum from Department of Family and Protective Services indicating that their investigators have received training on conducting sexual abuse investigations in order to be in compliance with this standard.

Resolution: The facility's Executive Director/PREA Coordinatot did provide a memorandum from Department of Family and Protective Services indicating that their investigators have received specialized training on how to conduct sexual abuse investigations, therefore demonstrating compliance with this standard.

Standard 115.335 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance Policy, Texas Children's Hospital Contract/Agreement if applicable, Signed PREA Training Roster, Specialized PREA Training Certificates for Mental Health Practitioner and Mental Health Consultant, and interview with the Director of Programs.

Findings: A. The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy does indicates that they do not conduct forensic medical exams on a youth for sexual abuse but if applicable, that they will refer the alleged victim to the Texas Children's Hospital in Houston, Texas where the examination would occur free of charge. B. There are no medical staff in this facility and the Texas Children's Hospital's SANE Nurse did indicate that they have not conducted a SANE examination for this facility's youth population in the last 12 months. C. The interview with the contracting mental health consultant at this facility indicated that he has received the specialized training in PREA and the auditor was provided with his certificate of the same. The Director of Programs also has receive this specialized training and the auditor was provided with a copy of her certificate as evidence that it has occurred, thus demonstrating compliance with this standard.

Corrective Action Findings: None
Resolution: Not applicable

Standard 115.341 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance Policy, Electronic and or Hard Copy of the Screening Instrument as applicable, Interviews with Random Youth, the Intake Staff, Director of Programs and with the Executive Director/PREA Coordinator.

Findings: A. The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy does outlines that the screening of youth during Intake must occur within 72 hours. B, C and D. The facility's screening instrument does not contains all of the eleven (1-11) screening elements required of this standard and does not contain the questions which covers the youth own perception of vulnerability as well as any observations made by the Intake staff regarding a youth's LGBTI, gender non-conforming or perceived vulnerable appearance. The facility's Intake staff did indicate that they do not have a process but one will be included in their Zero Tolerance policy for the re-assessment of a youth. E. The Intake staff did indicate during the interview that the information obtained during the initial screening which is sensitive, has limited dissemination and access to prevent exploitation to the detriment to the youth, that appropriate controls are in place and that they are under lock and key for protection. Interviews conducted with the Intake staff and the Director of Programs as well as questions asked of the youth at random revealed that these facility controls are in place.

Corrective Action Findings: The facility must provide evidence in the form of their revised assessment form that the eleven elements required for the behavior assessment as indicated in B, C and D of this standard are included and are utilized for all new intakes during this corrective action period including that a protocol will be put in place for the reassessment of a youth in order to be in compliance with this standard.

Resolution: The facility's Executive Director/PREA Coordinator did provide evidence in the form of a copy of their revised assessment form reflecting that the eleven elements required for the behavior assessment as indicated in B, C and D of this standard are included and has been utilized for all new intakes (one new youth) during this corrective action period. She also included in their Zero Tolerance policy that a protocol has been put in place for the reassessment of a youth every 30 days, therefore demonstrating compliance with this standard.

Standard 115.342 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance, Shamar Hope Haven Policy and Procedure Manual, Isolation/Segregation Policies if applicable, Intake Staff and Executive Director/PREA Coordinator Interviews, Intake Screening Instrument, Isolation/Segregation Logs if applicable, and a review of the Behavior Classification/Housing Assignment Log, if applicable.

Findings: A. The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy was provided to the auditor for review and the facility's Intake staff was able to demonstrate how the screening instrument is used to make informed housing assignments, which is discussed weekly with the Director of Program, Direct Care Staff Supervisor and the Executive Director after Intake. B. The facility's Zero Tolerance policy does prohibit the use of isolation thus automatically prohibiting the placement of youth in isolation due to risk of sexual victimization. The facility does not utilize nor have space to isolate a youth because it is a non-secure facility and the Executive Director/PREA Coordinator indicated during her interview that she would provide a memorandum as evidence indicating that seclusion (isolation) is not used for sexual abuse and sexual harassment for a victim and or for perpetrators. C and D. A copy of the Behavior Screening form was provided to the auditor for review and he was informed by the Director of Programs that housing assignments is not based on LGBTGNC status, perceived status or identification status as an indicator of likelihood of being sexually abusive. This is an all-male, non-secure facility. The facility's Executive Director/PREA Coordinator did indicate that they did not have any identified Transgender or Intersex youth in their population during this onsite audit. E, F and G. The facility's Zero Tolerance policy does state that it will also allow for an Intersex and Transgender youth to shower separately and that they would be re-assessed twice a year to review any threats to safety if any were experienced by the youth. The Executive Director/PREA Coordinator and the Intake staff also indicated that serious considerations with respect to a youth's safety would be given if a Transgender or Intersex youth were in their population. H and I. During the last 12 months the facility reported that there were zero youth placed in isolation, that zero youth were denied daily access to services and that zero youth did not average any time in isolation, though this facility is non-secure, having no rooms designated for isolation.

Corrective Action Findings: The facility must provide a memorandum as evidence stating that isolation will and has not been used due to a youth's risk of sexual victimization and that isolation was not used in the last 12 months for a sexual abuse and sexual harassment victims and or perpetrators in order to demonstrate compliance with this standard.

Resolution: The facility's Executive Director/PREA Coordinator did provide a memorandum as evidence stating that isolation has not been used due to a youth's risk of sexual victimization in the last 12 months and that isolation will not used in this non-secure facility for a sexual abuse and sexual harassment victims and or perpetrators, therefore demonstrating compliance with this standard

Standard 115.351 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance, Shamar Hope Haven Policy and Procedure Manual, Grievance Policy, if applicable, PREA Posters, posted Hotline Numbers, Staff and Youth Interviews, and the Third Party Reporting Policy, if applicable.

Findings: A. The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy does provide for multiple internal ways (i.e. grievance, trusting adult) and also provides several external numbers (i.e. DFPS Child Abuse Hotline) for a youth to privately report allegations of sexual abuse and sexual harassment. B. One such number for reporting an allegation is to the Department of Family and Protective Services (DFPS) which is a toll free 1-800- 586-9431 number posted on the bulletin board in each House and in the administrative building that was observed by this auditor. C. Interviews conducted with the facility's random staff and the youth demonstrated their knowledge of this, confirmed that the youth have unimpeded access to the phone to make these calls in accordance with this standard; that staff do and will accept, document and do immediately report all verbal reports of sexual abuse and sexual harassment from a youth to the appropriate upper level supervisory and or administrative staff. D. The facility's staff did indicate during their interviews that the youth are also provided with a grievance form as one of the tools for reporting an allegation. E. During the staff and youth interviews they also informed the auditor that they can report sexual abuse and sexual harassment allegations privately, confidentially, anonymously and or through a 3rd party at any time. The staff can use the same Department of Family Protective Services hotline number for making such reports or talk to a supervisor privately. The facility's Zero Tolerance policy did reflect and the Executive Director/PREA Coordinator did cooroborate it that they do not detain youth for civil immigration purposes.

Corrective Action Findings: The facility must provide a memorandum as evidence that they do not detain youth for civil immigration purposes in order to be in compliance with this standard.

Resolution: The facility's Executive Director/PREA Coordinator did provide a memorandum as evidence stating that they do not detain youth for civil immigration purposes, therefore demonstrating compliance with this standard.

Standard 115.352 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance, Shamar Hope Haven Policy and Procedure Manual, Grievance Policy, Retaliation Monitoring Form, Grievance Logs if applicable, Investigation Case Logs that exceeded 90 days or Required an Extension of 70 days if applicable, Disciplinary Action taken for Bad Faith filings if applicable, Investigator's interview if applicable, and Random Staff and Youth Interviews.

Findings: A, B and C. The Shamar Hope Haven Residential Treatment Center Grievance policy does not state that the do not impose a time limit regarding filing an allegation for sexual abuse, but does indicate that a youth cannot resolve a sexual abuse grievance with the alleged staff person informally and that it will not referred to the alleged staff member for resolution. D. The facility's Zero Tolerance and Grievance policies do not state that they shall issue a final decision to the youth within 90 days of the initial filing. E. The facility's Zero Tolerance policy does state that a 3rd party can file a grievance on behalf of a youth and that a youth will be monitored for retaliation up to 90 days or until the investigation is closed or is unfounded. F. The Executive Director/PREA Coordinator did provide the auditor with a copy of the youth grievance form and described how they can file their grievance and grievance policy does describes the youth grievance procedure including the filing of emergency grievances. G. A review of the facility's grievance policy revealed that it does not state that disciplinary action can be taken against a youth if a grievance is filed in bad faith. The Shamar Hope Haven Residential Treatment Center

did not provide in writing but the Executive Director/PREA Coordinator did indicate that there were zero grievances filed in the last 12 months alleging sexual abuse and sexual harassment, that zero emergency grievances filed in the last 12 months, and that there were zero sexual abuse and sexual harassment grievances and or administrative and criminal investigations that were not completed within 90 days or that required extensions up to 70 days, since they did not have any.

Corrective Action Findings: The facility must provide a copy of their edited Grievance policy as evidence inclusive of the language from "A, B, C, D, E and G" of this standard and provide a memorandum as evidence indicating that there were zero reported grievances for sexual abuse and sexual harassment filed in the last 12 months in order to be in compliance with this standard.

Resolution: The facility's Executive Director/PREA Coordinator did provide a copy of their edited Grievance policy as evidence reflective of the language from "A, B, C, D, E and G" of this standard and did provide a memorandum as evidence indicating that there were zero reported grievances for sexual abuse and sexual harassment filed in the last 12 months, therefore demonstrating compliance with this standard

Standard 115.353 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance, Shamar Hope Haven Policy and Procedure Manual, Visitation Policy, Rape Crisis Center and or Advocacy Agency Memorandum of Agreement, Youth Orientation Manual (Handbook) if applicable, PREA Posters and other Documentation, Facility's Schematics of Visitation Area and or Space, Random Staff, Youth, and Executive Director/PREA Coordinator Interviews.

Findings: A. The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy does outline how a youth would have access to outside confidential support services if needed in the event of they are a sexual abuse victim. The facility did not provided the youth with this information regarding their access to outside and other services i.e. Rape Crisis Center during Intake and Orientation but have provided information in the youth orientation packet which also contains the toll free and or local phone numbers for reporting abuse. B and C. The facility did not provide written evidence of an established Memorandum of Understanding with and Rape Crisis Center and or with an Advocacy Center for the provision of emotional support and crisis counseling services as needed for victims of sexual abuse. The youth interviewed could not recall being given this information on outside support services during the Intake/Orientation process and none of them knew that they could communicate with an outside service providers privately, that their conversation is confidential, and none of the youth indicated that this was discussed with them. D. The facility's Zero Tolerance policy does indicate that they provide the youths with reasonable and confidential access to their parents, legal guardians and lawyers for visitation which was supported by the staff and youth interviews including a review of the facility schematics for designated visitation space.

Corrective Action Findings: The facility must provide written evidence of a Memorandum of Understanding and or Agreement with a local Rape Crisis Center for the provision of emotional support and crisis counseling for sexual abuse victims, must provide and display that agency's information including their number in both houses, must re-educate the youth on these services and provide a signed training roster that this information has been disseminated to the youth including providing pictures that it has been posted in both Houses and in the administrative building in order to be in compliance with this standard.

Resolution: The facility's Executive Director/PREA Coordinator did provide written evidence of a Memorandum of Understanding from the Sexual Assault Resource Center (SARC) for the provision of emotional support and crisis counseling for sexual abuse victims, she did provide pictures displaying that agency's information including their number in both houses and the administrative building, she also provided a memorandum stating that all youth have been re-educated on this agency's service including signed training rosters demonstrating that this information has been disseminated to the youth, therefore demonstrating compliance with this standard

Standard 115.354 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance, Shamar Hope haven Policy and Procedure Manual, Grievance and Third Party Reporting Policy and Form if applicable, the Agency Website, Staff and Youth Interviews, copy of Youth Grievance Form, and the Executive Director/PREA Coordinator's Interview.

Findings: A. The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy does establishes the method outlined to receive and or for making a 3rd party report of sexual abuse and sexual harassment on behalf of a youth and that this information will also available on their website as reviewed by this auditor. The facility's Executive Director/PREA Coordinator did provide written evidence for the link to this website. The Shamar Hope Haven Residential Treatment Center did not provide the auditor with a copy of the Parent brochure on PREA nor a sample copy of the 3rd party Grievance Report form used by a 3rd party for reporting abuse, neglect, exploitation, sexual abuse and sexual harassment. Knowledge of this practice was verified during the Executive Director/PREA Coordinator's interview but was not substantiated during the random youth interviews.

Corrective Action Findings: The facility must provide as evidence in their of the 3rd party reporting process, post it on their website as to how a 3rd party can report a sexual abuse and sexual harassment allegation on behalf of a youth in the facility and re-educated the youth on 3rd party reporting process including providing signed training rosters as evidence of this training in order to be in compliance with this standard.

Resolution: The facility's Executive Director/PREA Coordinator did provide as evidence in the 3rd party reporting process including provide a sample document for completion, have posted on their website as to how a 3rd party can report a sexual abuse and sexual harassment allegation on behalf of a youth in the facility and did provide signed training rosters from the youth who have been re-educated on the 3rd party reporting process, therefore demonstrating compliance with this standard

Standard 115.361 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance Policy, Rape Crisis and or Advocacy Center's Memorandum of Agreement if applicable, Shamar Hope Haven Policy and Procedure Manual, Intake Staff, Referral or Serious Incident Report Form to Outside Law Enforcement or Investigative Entity, Mental Health Consultant, Director of Programs, Executive Director/PREA Coordinator, PREA Compliance Manager if applicable and Random Staff Interviews.

Findings: A. The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy does require for all staff to immediately report to the supervisor, Director of Programs and to the Executive Director any suspicion, knowledge, or information of an allegation of sexual abuse, sexual harassment, retaliation and staff policy violation for neglect of their responsibilities that may contribute to the incident or retaliation, including 3rd party reports. The facility's Executive Director/PREA Coordinator also provided the auditor with a copy of their Policy and Procedure Manal regarding their internal processes, personnel actions, the first responders responsibilities and duties of the staff but did not include how referrals are to be made to the local Rape Crisis Center and the local Advocacy Center for mental health assessment and treatment, as necessary for a victim of sexual abuse. B and D. The facility's Zero Tolerance policy does indicate that all staff are mandatory reporters, which was also verified during the random staff interviews. The facility's Zero Tolerance policy does direct the facility staff, including their mental health consultant and contractors as mandatory reporters of child abuse, that they need to immediately report this information, complete a serious incident report and forward it to the Director of Programs. C. The facility's Zero Tolerance policy does state the prohibition of the staff from revealing any information related to the sexual abuse and sexual harassment allegation to anyone other than to the extent necessary. E and F. The Director of Programs reports the allegation to the Executive Director and then to the Department of Family Protective Services and or to the Houston Police Department as appropriate. During the random staff interviews it was ascertained that the srandom staff did demonstrate knowledge regarding their reporting responsibilities including the notifications to be made to their immediate supervisor, the Director of Programs, Houston Police Department, the Department of Family Protective Services, the alleged victim's parent, legal guardian, and lawyers and to the court of jurisdiction, as applicable.

Corrective Action Findings: The facility must provide as evidence a copy of the Memorandum of Understanding or Agreement from a local Rape Crisis Center and or Advocacy Center and a memorandum indicating that all parties i.e. victims, parents, etc. would be notified in the event of a sexual abuse allegation in order to be in compliance with this standard.

Resolution: The facility's Executive Director/PREA Coordinator did provide a copy of the Memorandum of Understanding from the Sexual Assault Resource Center (SARC) and a did provide a memorandum indicating that all parties i.e. victims, parents, etc. would be notified in the event of a sexual abuse allegation, therefore demonstrating compliance with this standard.

Standard 115.362 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance, Shamar Hope Haven Policy and Procedure Manual, Isolation/Segregation Policies and logs as applicable, Executive Director/PREA Coordinator, Director of Programs, Specialized and Random Staff Interviews.

Findings: A. The Shamar Hope Haven. Residential Treatment Center Zero Tolerance policy does outlines their internal processes regarding the agency's protection duties when informed that a youth is subject to substantial risk of imminent sexual abuse. The specialized and random staff interviews verified their knowledge of and the requirement in order to be in compliance with this policy. The Executive Director/PREA Coordinator did indicate that they do not utilize isolation since this is a non-secure facility residential facility and that they had zero youth placed in isolation during the last 12 months who were subject to any type of substantial risk of imminent sexual abuse while in their facility.

Corrective Action Findings: The facility must provide as evidence a memorandum stating that during the last 12 months zero youths were not subject to any type of substantial risk of imminent sexual abuse while in their facility in order to be in compliance with this standard.

Resolution: The facility's executive Director/PREA Coordinator did provide as evidence in the form of a memorandum stating that during the last 12 months there were zero youths who were not subject to any type of substantial risk of imminent sexual abuse while in her facility, therefore demonstrating compliance with this standard.

Standard 115.363 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance Policy, Shamar Hope Haven Policy and Procedure Manual, Allegation Notification to Other Facilities if applicable, Investigative administrative or Criminal Case files if applicable, Executive Director/ PREA Coordinator and Intake Staff interviews.

Findings: A. and B The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy does outline the staff's requirement of reporting to other confinement facilities within 72 hour of being informed during Intake of an allegation being made by a youth of sexual abuse and sexual harassment and that it will be documented in the youth's file. The interview conducted with the Intake staff as well as with the specialized staff demonstrated their knowledge and understanding of this reporting requirement and policy adherence. C. The Shamar Hope Haven Residential Treatment Center Executive Director/PREA Coordinator did indicate that they had zero reported cases of reporting to another confinement facility for an allegation of sexual abuse that occurred in that facility within the past 12 months during their interviews. The random staff were able to recite during their interviews this notification protocol. D. The facility's Executive Director/PREA Coordinator did not provide but indicated that she would provide a memorandum as evidence to demonstrate that an alleged facility would have been notified well within 72 hours of the sexual abuse and sexual harassment allegation and that they would ensure that the case is properly investigated and closed by the appropriate investigative entities as required by this standard.

Corrective Action Findings: The facility must provide written evidence in the form of a memorandum that an alleged facility would be notified within 72 hours of a sexual abuse allegation and would ensure that the case is properly investigated by the appropriate investigative entity in order to be in compliance with this standard.

Resolution: The facility's Executive Director?PREA Coordinator did provide written evidence in the form of a memorandum that an alleged facility would be notified within 72 hours of a sexual abuse allegation from a youth and that she would ensure that the case is properly investigated by the appropriate investigative entity by staying in contact with them, therefore demonstrating compliance with this standard.

Standard 115.364 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance Policy, PREA-Related Training Curriculums, Investigative Case files if applicable, First Responder, Non-Security Staff, Random Staff, and the Executive Director/PREA Coordinator's Interviews.

Findings: A and B. The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy does outline the first responder's duties for responding to sexual abuse and sexual harassment allegations in this facility. The facility reported that there were zero allegations of

sexual abuse and sexual harassment whereas the collection of evidence though not applicable, would have been collected in the appropriate time frame as required by this standard. The facility reported that there was zero times that the crime scene and or evidence needed to be preserved, zero times was requested of a victim not to take any action, zero times requested of the abuser not to take action, zero times that non-security staff had to respond, and that in all times, when applicable, the security (direct care) staff would have been notified and would have promptly responded to the allegation (s). During the random staff interviews they were able to articulate their knowledge, understanding, responsibilities and duties as a first responder but did not articulate that they would inform the victim and the abuser not to destroy evidence by washing, eating, changing clothes, drinking, defecating or brushing teeth. The facility had reported zero allegations of sexual abuse and sexual harassment during the past 12 months and that the first responder would have acted in accordance with the agency's policy and the facility's protocol.

Corrective Action Findings: The facility must provide written evidence in the form of signed training rosters that all of the direct care staff have been re-trained in their first responder duties specifically on informing the victim and perpetrator not to take any action during a sexual abuse incident and that in the last 12 months there were zero allegation of sexual abuse where a first responder had to act in order to be in compliance with this standard.

Resolution: The facility's Executive Director/PREA Coordinator did provide written evidence in the form of signed training rosters that all of the direct care staff have been re-trained in their first responder duties, specifically, on informing the victim and perpetrator not to take any action during a sexual abuse incident and that in the last 12 months there were zero allegation of sexual abuse where a first responder had to act, therefore demonstrating compliance with this standard.

Standard 115.365 Coordinated response

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

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

Policy and Evidence to be reviewed: Draft Zero Tolerance Policy, Shamar Hope Haven Policy and Procedure Manual, Copy of Facility's Written Plan for Coordinated Response to Sexual Abuse Allegation, Sexual Abuse Review Team Member, Investigator as applicable and the Executive Director/PREA Coordinator Interviews.

Findings: A. The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy does outline the procedure for specific staff's response to allegations of sexual abuse and sexual harassment. Interviews conducted with the random staff, the Executive Director/PREA Coordinator and with a member of a Sexual Abuse Review Team member reflected their knowledge of the process for reporting a sexual abuse and sexual harassment allegation, the responsibilities of the Director of Programs, the Mental Health Consultant, and the responsibilities of a First Responders according to this plan. The Executive Director/PREA Coordinator did not provide the auditor with a copy their written coordinated response plan though.

Corrective Action Findings: The facility must provide a copy of their written coordinated plan as evidence and a copy of the training roster that all of the employee have been informed of this plan and that it has been institutionalized for reporting allegations of sexual abuse and sexual harassment in order to be in compliance with this standard.

Resolution: The facility's Executive Director/PREA Coordinator did provide a copy of their written coordinated plan as evidence, a copy of the training roster reflecting that all of her employees have been informed of this plan coupled with pictures of this plan posted in the facility and that it has become institutionalized for reporting allegations of sexual abuse and sexual harassment, therefore demonstrating compliance with this standard.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance policy, Shamar Hope Haven Policy and Procedure Manual, and the Executive Director/PREA Coordinator Interview.

Findings: A and B. The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy does state that they do not enter into collective bargaining agreements and that the policy does allow for an alleged staff abuser to be removed from contact with a youth pending an investigation or of a determination of whether and what extent discipline is warranted.

Corrective Action Findings: The facility must provide a memorandum as evidence stating that they do not enter into collective bargaining agreements and include the language in their the Zero Tolerance policy that will allow for an alleged staff abuser to be removed from contact with a youth pending an investigation or of a determination of whether and what extent discipline is warranted in order to be in compliance with this standard.

Resolution: The facility's Executive Director/PREA Coordinator did provide a memorandum as evidence stating that they do not enter into collective bargaining agreements and did include this language in their the Zero Tolerance policy that will allow for an alleged staff abuser to be removed from contact with a youth pending an investigation or of a determination of whether and what extent discipline is warranted, therefore demonstrating compliance with this standard.

Standard 115.367 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance policy, Retaliation Policy if applicable, Shamar Hope Haven Policy and Procedure Manual, Protective Measure Policy and Forms, if applicable, Rape Crisis Center and or Advocacy Center's Memorandum of Agreements if applicable, Internal Investigator, if applicable and the Executive Director/PREA Coordinator's Interview.

Findings: A. The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy does outline their response to retaliation and protection for all youth and staff members who report an allegation of sexual abuse and sexual harassment and or who cooperate with an investigation. The facility has designated the Director of Programs as the responsible individual for monitoring youth and staff against retaliation for reporting a sexual abuse or sexual harassment allegation. B. The facility's Zero Tolerance policy does indicate that they employ multiple protective measures to protect a youth ranging from changing housing (House) assignments, to removing them from the facility to another, removing the abuser or alleged staff member from contact with the victim, and will provide emotional support and crisis counseling to the victim. C and D. The facility's Zero Tolerance policy does indicate that a youth's conduct would be monitored up to 90 days against retaliation, including periodic status checks ensuring that they would promptly remedy any such retaliation and would provide treatment services as needed. E. The facility's Zero Tolerance policy also indicates that they will protect any other individual who

cooperates with an investigation who may express fear of retaliation. F. The facility's Zero Tolerance policy does state that their obligation to monitor shall terminate if the allegation is determined Unfounded. The facility's Executive Director/PREA Coordinator did indicate that there was zero times where protective measures were required to protect staff and or youth against retaliation in the last 12 months.

Corrective Action Findings: The facility must provide a memorandum as written evidence indicating that there was zero times where protective measures were required to protect staff and or youth against retaliation in the last 12 months in order to be in compliance with this standard.

Resolution: The facility's executive Director/PREA Coordinator did provide a memorandum as written evidence indicating that there were zero times where protective measures were required to protect staff and or youth against retaliation in the last 12 months, therefore demonstrating compliance with this standard.

Standard 115.368 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance, Shamar Hope Haven Policy and Procedure Manual, Isolation/Segregation Policies and Logs if applicable, Random Staff and Executive Director/PREA Coordinator's Interviews.

Findings: A. The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy does state the prohibition on the use of segregation (isolation) and or seclusion housing to protect a youth who have alleged sexual abuse and sexual harassment. This is a non-secure facility and the facility's Executive Director/PREA Coordinator did indicate that they do not utilized isolation in this facility and that there were zero youths who were held in isolation for protection who alleged sexual abuse and sexual harassment or who suffered sexual abuse in the last 12 months.

Corrective Action Findings: The facility must provide a memorandum as evidence stating that that they do not utilized isolation in this facility and that there were zero youths who were held in isolation for protection who alleged sexual abuse and sexual harassment or who suffered sexual abuse in the last 12 months in order to be in compliance with this standard.

Resolution: The facility's Executive Director/PREA Coordinator did provide a memorandum as evidence stating that that they do not utilized isolation in this non-secure facility and that there were zero youths who were held in isolation for protection who alleged sexual abuse and sexual harassment or who suffered sexual abuse in the last 12 months, therefore demonstrating compliance with this standard.

Standard 115.371 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

corrective actions taken by the facility.

Policy and Evidence to be reviewed: Draft Zero Tolerance, Shamar Hope Haven Policy and Procedure Manual, Investigative Policies as applicable, Internal and or External Investigator Interviews as applicable, Internal Investigator's Training Records as applicable Administrative and Criminal Investigative Cases as applicable, and the Executive Director/PREA Coordinator's Interview.

Findings: A. The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy does outline that they do not conduct administrative investigations but that the Department of Family and Protective Service (DFPS) will and that the Houston Police Department will conduct all criminal investigations of sexual abuse and sexual harassment. B. The Shamar Hope Haven Residential Treatment Center Executive Director/PREA Coordinator did indicate that she will provide written evidence in the form of a memorandum from DFPS regarding their investigator's specialized training. C. She indicated that the requested memorandum from DFPS will describe their gathering process i.e. evidence, videos, interviews, etc. and review of prior complaints and reports of sexual abuse of the alleged perpetrator. The Shamar Hope Haven Residential Treatment Center did not provide written evidence of any cases where sexual abuse and sexual harassment had occurred at another facility or in their facility (there were none), but if any had occurred the Executive Director/PREA Coordinator did state that they would have been investigated by the appropriate entities. D and F. The facility also reported that zero cases were investigated but if any had occurred they would have been closed in accordance with facility's policy and the PREA standard. G, H, I and J. The facility reported that there were zero substantiated investigative cases had been referred for prosecution and if there were that they would retain these case files as long as the abuser is incarcerated or employed 5 years plus according to their policy and applicable law. K. The facility's Zero Tolerance policy does state that an employee's termination or the departure of the victim and or perpetrator's being out of the control of the facility shall not cause the investigation to be terminate and that polygraphs are not utilized. M. The facility indicated that since there are no internal investigators in this facility the Executive Director/PREA Coordinator did describe how she would remain in contact with DFPS and or the Houston Police Department if a sexual abuse allegation had occurred.

Corrective Action Findings: The facility must provide a memorandum as evidence that there were zero sexual abuse allegations made at another facility or in their facility during the last 12 months and a memorandum from the Department of Family and Protective Services regarding their investigator's specialized training in conducting sexual abuse investigations in order to be in compliance with this standard.

Resolution: The facility's Executive Director/PREA Coordinator did provide a memorandum as evidence that there were zero sexual abuse allegations made at another facility or in her facility during the last 12 months and did provide a memorandum from the Department of Family and Protective Services that their investigators have received specialized training in conducting sexual abuse investigations, therefore demonstrating compliance with this standard.

Standard 115.372 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance Policy, Shamar Hope Haven Policy and Procedure Manual, Investigation Policy if applicable, the Internal Investigator's Interview, if applicable and the Executive Director/PREA Coordinator's Interview.

Findings: A. The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy does state that the standard used for proof when determining substantiation of an allegation for sexual abuse and sexual harassment in an administrative investigations is the preponderance of evidence and that this standard of proof, as demonstrated in a memorandum, is used by the Department of Family Protective Services investigators, thus demonstrating compliance with this standard.

Corrective Action Findings: Not applicable
Resolution: None

Standard 115.373 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance Policy, Shamar Hope Haven Policy and Procedure Manual, Youth Notification Documentation (Letter) Sample, Administrative and or Criminal Investigative Cases and Interview with the Investigator, if applicable, Interview with the Executive Director/PREA Coordinator.

Findings: A and B. The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy does outline the facility's responsibility in notifying a youth regarding the initiation and the outcome of an administrative and criminal investigation for sexual abuse and sexual harassment. C and D. The facility's Zero Tolerance policy also outlines the notification process for a staff-on-youth allegation and a youth-on-youth allegation. The facility has reported zero sexual abuse and zero sexual harassment allegations during the past 12 months, and that if any had occurred they would have informed the youth of the outcomes and that the investigation would have been completed by the Department of Family Protective Services and or the Houston Police Department E. The facility did not provide written evidence of verification that notifications had been given to a youth during the initiation of and at the conclusion of an investigation since there were none reported in the last 12 months, whether it was for a youth-on-youth or staff-on-youth. The Executive Director/PREA Coordinator did provide a sample copy of a notification letter that would be given to the youth in the event one would occur. The facility reported that zero notifications were made and zero notifications were documented for an allegation of sexual abuse and sexual harassment of a youth. The Executive Director/PREA Coordinator did indicate that there have not been any indictments or any referrals for prosecution or convictions of an abuser for sexual abuse and sexual harassment in the last 12 months thus demonstrating compliance with this standard.

Corrective Action Findings: None
Resolution: Not applicable

Standard 115.376 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance, Shamar Hope Haven Policy and Procedure Manual, Human Resource Policy if applicable, Staff Disciplinary Action Letter (if applicable), Referrals Form to Law Enforcement Entity, and Interview with the Executive Director/PREA Coordinator.

Findings: A and C. The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy does outline the steps to be taken in order to discipline a staff for sexual abuse and sexual harassment and that this violation's sanction will be commensurate with the nature and circumstances of the act committed. B. The Shamar Hope Haven Residential Treatment Center's Executive Director/PREA Coordinator did

report that there have not been any staff disciplinary actions taken during the past 12 months due a to violation of the agency's Zero Tolerance policy of sexual abuse and sexual harassment and that termination would be the presumptive disciplinary sanction. D. The facility reported that there were zero referrals for sexual abuse and sexual harassment allegations made to local law enforcement or to a relevant licensing entity in the last 12 months.

Corrective Action Findings: The facility must provide as evidence a memorandum stating that there have not been any staff disciplinary actions taken during the past 12 months due a to violation of the agency's Zero Tolerance policy of sexual abuse and sexual harassment and that termination would be the presumptive disciplinary sanction and that there were zero referrals for sexual abuse. Also that there were zero referrals of sexual abuse and sexual harassment allegations made to a law enforcement or to a relevant licensing entity in the last 12 months in order to be in compliance with this standard.

Resolution: The facility's executive Director/PREA Coordinator did provide a memorandum stating that there have not been any staff disciplinary actions taken during the past 12 months due a to violation of the agency's policy of sexual abuse and sexual harassment and that termination would be the presumptive disciplinary sanction and that there were zero referrals for sexual abuse and sexual harassment allegations made to a law enforcement or to a relevant licensing entity in the last 12 months, therefore demonstrating compliance with this standard.

Standard 115.377 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance, Shamar Hope Haven Policy and Procedure Manual, Volunteer and Contractor's Policies if applicable, Volunteer and Contractor's Disciplinary Letter (if applicable), Referral to Local Law Enforcement and Licensing Entity (if applicable), and Interview with the Executive Director/PREA Coordinator.

Findings: A. The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy does prohibit volunteers and contractors from contact who have been alleged to engage in sexual abuse and sexual harassment misconduct with a youth and it outlines the steps to be taken when disciplining volunteers and contractors for sexual abuse and sexual harassment violations. B. The facility's Executive Director/PREA Coordinator has reported that there were zero cases where a volunteer and or a contractor received disciplinary action during the past 12 months due to violation of the agency's Zero Tolerance policy of sexual abuse and sexual harassment. The facility's Executive Director/PREA Coordinator did indicate that there were zero reports made to local law enforcement or to a relevant licensing body for a contractor or volunteer engaging in sexual abuse with a youth in the last 12 months.

Corrective Action Findings: The facility must provide a memorandum as evidence indicating that there were zero cases where a volunteer and or a contractor received disciplinary action during the past 12 months due to violation of the agency's Zero Tolerance policy of sexual abuse and sexual harassment and that there were zero reports made to local law enforcement or to a relevant licensing body for a contractor or volunteer engaging in sexual abuse with a youth in the last 12 months in order to demonstrate compliance with this standard.

Resolution: The facility's Executive Director/PREA Coordinator did provide a memorandum indicating that there were zero cases where a volunteer and or a contractor received disciplinary action during the past 12 months due to violation of the agency's Zero Tolerance policy of sexual abuse and sexual harassment and that there were zero reports made to local law enforcement or to a relevant licensing body for a contractor or volunteer engaging in sexual abuse with a youth in the last 12 months, therefore demonstrating compliance with this standard.

Standard 115.378 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance, Shamar Hope Haven Policy and Procedure Manual, Isolation/Segregation Policies as applicable, Administrative and or Criminal Investigative Cases as applicable, Youth Orientation Packet and Executive Director/PREA Coordinator's Interview.

Findings: A. The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy does prohibit denying a youth large muscle exercise, daily visits, educational programming, and access to other programs as a disciplinary sanction; and that it outlines the process for taking disciplinary action against a youth when they participate in sexual misconduct with another youth, staff, volunteer or contractor in the facility. B and E. The facility's Zero Tolerance policy does outline that a formal due process hearing must occur following an administrative finding which the sanctions are commensurate with the nature and circumstances of the abuse committed including when a finding of sexual contact with a staff proves that they did not consent to such contact. C and D. The disciplinary process according to their Zero Tolerance policy includes if the youth's mental disabilities and mental illness contributed to the behavior when determining sanctions and if therapy, counseling or other interventions shall be considered for the youth to participate in. F. The facility's Zero Tolerance policy does indicate that they do not impose disciplinary sanctions if a youth makes a report of sexual abuse and sexual harassment in good faith. G. The facility reported zero administrative finding for a youth-on-youth sexual abuse, zero criminal finding of a youth-on-youth sexual abuse and zero instances where disciplinary sanctions were imposed for a sexual abuse and sexual harassment substantiated allegation. The facility has a Zero Tolerance policy against all forms sexual abuse, sexual harassment and sexual misconduct in the facility which needs finalization. During this reporting period the facility reported that zero youths were placed in isolation as a disciplinary sanction for a youth-on-youth sexual abuse and sexual harassment allegation in the past 12 months.

Corrective Action Findings: The facility must provide a memorandum as evidence indicating that in the last 12 months there were zero administrative and criminal finding for sexual abuse, zero times disciplinary action was taken for a substantiated allegation and that they do not impose disciplinary sanctions if a youth makes a report of sexual abuse and sexual harassment in good faith; this language being included in their finalized their draft Zero Tolerance policy, in order to be in compliance with this standard.

Resolution: The facility's Executive Director/PREA Coordinator did provide a memorandum as evidence indicating that in the last 12 months there were zero administrative and criminal finding for sexual abuse, that zero times was disciplinary action taken for a substantiated allegation and that they do not impose disciplinary sanctions if a youth makes a report of sexual abuse and sexual harassment in good faith,. The facility's Executive Director/PREA Coordinator did provide an edited copy of their Zero Tolerance plicy reflecting that this language has been inserted in this policy, therefore demonstrating compliance with this standard.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance Policy, Shamar Hope Haven Policy and Procedure Manual, Mental and Medical Screening Instrument Form if applicable, Prior Sexual Victimization Referral Forms and or Listing if applicable, Youth Medical and Mental

Health Files and Follow Up Documentation if applicable, Medical if applicable, Mental Health Consultant, Director of Program, Executive Director/PREA coordinator, Random Staff Interviews and a review of the Facility's Schematics for Medical/Clinic/Infirmary if applicable..

Findings: A. The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy does outline the procedure to follow for medical and mental health screenings i.e. consisting of the youth's history of sexual abuse, etc. if applicable. The youth's hard files does contain some of this sensitive information which is not accessible to non-treatment staff in this facility but is accessible to the clinical and administrative personnel. B. The Shamar Hope Haven Residential Treatment Center did not identify any youths who had disclosed a prior sexual victimizations in the past 12 months, whether if occurred either at another confinement facility or in a community setting, and the Executive Director/PREA Coordinator did indicate that she would provide a memorandum as evidence demonstrating that if one had been disclosed that a medical and mental health follow up assessment would have been offered to these and other youths within 14 days of Intake; and or when prior sexual victimization would have been alleged to have occurred. C. The Mental Health Consultant and the Director of Programs did indicate during their interviews that they do maintain secondary information in their treatment and case management files, which are kept in an office under lock and key whereas only they have access to them. The facility's Zero Tolerance policy does state that all staff are considered mandatory reporters of child abuse according to the State of Texas law which includes the mental health practitioners. D. The facility's Zero Tolerance policy does indicate how consent is to be obtained from a youth, unless under the age of 18, where sexual abuse did not occur in an institutional setting.

Corrective Action Findings: The facility must provide a memorandum as evidence that demonstrates that if a prior sexual victimization had been disclosed at Intake that a medical and mental health follow up assessment would have been offered to that and other youths within 14 days of Intake and or when prior sexual victimization would have been alleged to have occurred in order to be in compliance with this standard.

Resolution: The facility's Executive Director/PREA Coordinator did provide a memorandum as evidence that demonstrates that if a prior sexual victimization had been disclosed at Intake that a medical and mental health follow up assessment would have been offered to that and other youths within 14 days of Intake and or when prior sexual victimization would have been alleged to have occurred, therefore demonstrating compliance with this standard.

Standard 115.382 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance Policy, Shamar Hope Haven Policy and Procedure Manual, Medical as applicable, Mental Health Practitioners Interviews, and a review of Youth Medical and Mental Health Files if applicable.

A. The Shamar Hope Haven Residential Treatment Center facility did report that there were zero cases of sexual abuse requiring medical attention at this facility during the past 12 months and that the facility's Zero Tolerance policy does outline how a youth will have access to these emergency services in a timely, unimpeded manner. B and C. The facility's Zero Tolerance policy does indicate that if no qualified medical or mental health practitioner is on duty what the first responders responsibilities are to protect the victim and ensure they are offered timely information and access to emergency contraception, and STI prophylaxis. D. The facility's Executive Director/PREA Coordinator did indicate that access to emergency medical and mental health services would be provided at the Texas Children's Hospital in Houston, Texas and that these treatment services shall be provided at no cost to the victim whether they name the abuser or cooperates with the investigation. The facility reported that there were zero sexual abuse and sexual harassment cases to review that required a youth emergency access to medical and mental health services in the last 12 months according to the Contracting Mental Health personnel and the Director of Programs during their interviews.

Corrective Action Findings: The facility must provide a memorandum as evidence indicating that a victim of sexual abuse would be offered timely information and access to emergency contraception and STI prophylaxis and that there were zero youths who required emergency access to medical and mental health services in the last 12 months in order to be in compliance with this standard.

Resolution: The facility's Executive Director/PREA Coordinator did provide a memorandum as evidence indicating that a victim of sexual abuse would be offered timely information and access to emergency contraception and STI prophylaxis and that there were zero youths who required emergency access to medical and mental health services in the last 12 months, therefore demonstrating compliance with this standard.

Standard 115.383 Ongoing medical and mental health care for sexual abuse victims and abusers

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

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

Policy and Evidence to be reviewed: Draft Zero Tolerance Policy, Shamar Hope Haven Policy and Procedure Manual, Medical and Mental Health Treatment Policies if applicable, Treatment Services Referral Form if applicable, Medical (if applicable), Mental Health Consultant, Director of Programs and the Executive Director/PREA Coordinator's Interviews.

Findings: A. The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy does outline the procedure for a sexual abuse victim and or abuser to be offered an evaluation that have been victimized including receiving ongoing medical and mental health care. B, D, E, F and G. The facility's Director of Programs and the Executive Director/PREA Coordinator did indicate that the these services would be provided to those youth who have been adjudicated and who are assigned to their program, that the services are provided free of charge to the youth, pregnancy tests (which is not applicable here since this is an all-male facility) as well as other treatment i.e. STI's as deemed appropriate by the medical and mental health practitioner will be offered. C. The Mental Health Contractor and the Director of Programs did indicate during their interviews that the mental health services are consistent with the community level of care and are at no cost to the victim whether they name the abuser or cooperates with the investigation. H. The facility's Director of Programs did indicate that they would attempt to conduct an evaluation on the committed youth abuser within 60 days of learning of the abuse history and offer treatment when deemed appropriate by the mental health practitioner. The Shamar Hope Haven Residential Treatment Center reported that there were zero youth identified as a sexual abuse victim and or abuser who required ongoing medical and mental health services during the last 12 months.

Corrective Action Findings: The facility must provide a memorandum as evidence to demonstrate that there were zero youth identified as a sexual abuse victim and or abuser who required ongoing medical and mental health services during the last 12 months in order to be in compliance with this standard.

Resolution: The facility's Executive Director/PREA Coordinator did provide a memorandum as evidence to demonstrate that there were zero youth identified as a sexual abuse victim and or abuser who required ongoing medical and mental health services during the last 12 months, therefore demonstrating compliance with this standard.

Standard 115.386 Sexual abuse incident reviews

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion

must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy and Evidence to be reviewed: Draft Zero Tolerance Policy, Shamar Hope Haven Policy and Procedure Manual, Sexual Abuse Review Team Initial and Ongoing Meeting Minutes, Monthly Meeting Email Notification (if applicable), Administrative and Criminal Investigative Cases if applicable, Interview with a member of the Sexual Abuse Review Team and the Executive Director/PREA Coordinator.

Findings: A. The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy does outline the process for conducting sexual abuse reviews for substantiated and unsubstantiated cases of sexual abuse and sexual harassment and that a review would not be held for any Unfounded cases. B and C. Their Sexual Abuse Review Team is represented by the Director of Programs, the Executive Director/PREA Coordinator, and the Mental Health Consultant, the Department of Family and Protective Services Investigator (as applicable) and a Shift supervisor; and that the meeting would convene within 30 days of the conclusion of an administrative and or criminal investigation for sexual abuse and sexual harassment. D and E. A Sexual Abuse Review Team member was interviewed including the Executive Director/PREA Coordinator and they did indicate that they do consider the six (6) elements of this review and would document and submit its findings, that the meeting would be facilitated by the Executive Director/PREA Coordinator, that she would prepare the minutes and report recommendations for improvement as applicable. The Shamar Hope Haven Residential Treatment Center did not provide written evidence to the auditor of any copies of the meeting minutes for the last 12 months to demonstrate that the sexual abuse team was actively meeting monthly. The auditor recommended as a best practice to the PREA Coordinator that she send an e-mail to all the Sexual Abuse Review Team members to kept them apprised monthly if there are any sexual abuse and sexual harassment allegations cases to be reviewed and that in the months where there are no meetings that a memorandum be sent indicating the same and filed. The facility has reported zero allegations of sexual abuse and sexual harassment during the last 12 months with zero sexual abuse reviews being conducted.

Corrective Action Findings: The facility must provide written evidence of the minutes from their initial Sexual Abuse Review Team meeting formation and subsequent memorandums for the next 3 months indicating that there were zero allegations of sexual abuse and sexual harassment whereas the SARB Team had to convene in order to demonstrate compliance with this standard.

Resolution: The facility's Executive Director/PREA Coordinator did provide written evidence of the minutes from their initial Sexual Abuse Review Team meeting formation and subsequent memorandums for the months of October, November and December indicating that there were zero allegations of sexual abuse and sexual harassment whereas the SARB Team had to convene, therefore demonstrating compliance with this standard.

Standard 115.387 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence to be reviewed: Draft Zero Tolerance Policy, Shamar Hope Haven Policy and Procedure Manual, DOJ Survey for Sexual Victimization for 2014 if applicable, Administrative and Criminal Investigative Cases if applicable, Sexual Abuse and Sexual Harassment Allegations for 2014, Trends, Implemented Recommendations if applicable, etc. and Interview with the Executive Director/PREA Coordinator.

Findings: A. The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy does outline the procedure for collecting uniform data on all allegations of sexual abuse and sexual harassment in this facility including private contractors, if applicable, using a standardized instrument to demonstrate compliance with this standard. B and C The Shamar Hope Haven Residential Treatment Center did not provide written evidence of their annual DOJ Survey of Sexual Victimization because they do not participate in this DOJ survey but did indicate that they would utilize a similar standardized instrument for capturing this aggregate data annually, which was confirmed through an interview with the agency's Executive Director/PREA Coordinator. D and E. The facility's Executive Director/PREA Coordinator did indicate that she will review, collect all the data including investigative reports and files, identifies trends, implements recommendations and documents the

reason for not doing so locally. The Executive Director/PREA Coordinator did indicate that upon request, this information would be provided to DOJ no later than June 30th though this information has not been requested from DOJ, thus demonstrating compliance with this standard.

Corrective Action Findings: None
Resolution: Not applicable

Standard 115.388 Data review for corrective action

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

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

Policy and Evidence to be reviewed: Draft Zero Tolerance Policy, Shamar Hope Haven Policy and Procedure Manual, the Facility's Aggregated Sexual Abuse and Sexual Harassment Data if applicable and Interview with the Executive Director/PREA Coordinator.

Findings: A and B. The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy does outline their review of aggregate sexual abuse and sexual harassment data, including that of their private contractors if applicable, to assess and improve the effectiveness of the their agency's policies, practices, training, while identifying problems and taking the necessary corrective action. The facility's Executive Director/PREA Coordinator did not provide written evidence that demonstrated a review of the data collected since there were none, nor were there any identified trends, problem areas, and or subsequent corrective action to be taken with regards to this standard. C and D. The facility's Executive Director/PREA Coordinator did indicate during her interview that she would prepare a report of any findings, would compare the current year's data with the prior year data as applicable, redacting any information that may present a clear and specific threat to the safety and security of the facility, obtain approval from the agency's Board of Director, make available on the agency's website or by other means and would provide a copy to the Department of Justice upon their request, thus demonstrating compliance with this standard.

Corrective Action Findings: None
Resolution: Not applicable

Standard 115.389 Data storage, publication, and destruction

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

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

Policy and Evidence to be reviewed: Draft Zero Tolerance Policy, Shamar Hope Haven Policy and Procedure Manual, Data Collection and Review of Sexual Abuse and Sexual Harassment Incidents if applicable, and Interview with the Executive Director/PREA Coordinator.

Findings: The Shamar Hope Haven Residential Treatment Center Zero Tolerance policy does outline that all sexual abuse data, though there are none, that is under their control would be kept and that all personal identifiers would be redacted; noting that this information is retained securely. A review of this facility's Zero Tolerance policy and further discussion with the Executive Director/PREA Coordinator confirmed this practice is being adhered to. Furthermore, the Shamar Hope Haven Residential Treatment Center's Zero Tolerance policy does indicate that all sexual abuse data would be retained securely and would be maintained for at least 10 years after the date of the initial collection, thus demonstrating compliance with this standard.

Corrective Action Findings: None
Resolution: Not applicable

AUDITOR CERTIFICATION

I certify that:

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

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

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

Jerome K. Williams _____ February 9th, 2017

Auditor Signature Date