Prison Rape Elimination Act (PREA) Audit Report
Juvenile Facilities

☐ **Interim** ☒ **Final**

Date of Report August 24th, 2020

Auditor Information

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Company Name: N/A	
Mailing Address: 749 Rutherford Dr	**City, State, Zip:** Crowley, Texas 76036
Telephone: 512-636-8137	**Date of Facility Visit:** January 8th, 9th, and 10th, 2020

Agency Information

Name of Agency Shamar Hope Haven Residential Treatment Center		**Governing Authority or Parent Agency** *(If Applicable)* Not Applicable	
Physical Address: 2719 Truxillo		**City, State, Zip:** Houston, Texas 77004	
Mailing Address: 2913, Wheeler St		**City, State, Zip:** Houston, Texas 77004	
The Agency Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

Agency Website with PREA Information: www.shamarhopehaven.org

Agency Chief Executive Officer

Name: Sharon Evans, Executive Director	
Email: EvansSevans@aol.com	**Telephone:** 713-942-8822

Agency-Wide PREA Coordinator

Name: Sharon Evans, Executive Director / PREA Coordinator	
Email: EvansSevans@aol.com	**Telephone:** 713-942-8822
PREA Coordinator Reports to: Executive Director	**Number of** Compliance Managers who report to the PREA Coordinator: 1

Facility Information

Name of Facility: Shamar Hope Haven Residential Treatment Center			
Physical Address: 2719 Truxillo		**City, State, Zip:** Houston, Texas 77004	
Mailing Address (if different from above): 2913, Wheeler St		**City, State, Zip:** Houston, Texas 77004	
The Facility Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

Facility Website with PREA Information: www.shamarhopehaven.org

Has the facility been accredited within the past 3 years? ☐ Yes ☒ No

If the facility has been accredited within the past 3 years, select the accrediting organization(s) – select all that apply (N/A if the facility has not been accredited within the past 3 years):

☐ ACA

☐ NCCHC

☐ CALEA

☐ Other (please name or describe: Click or tap here to enter text.

☒ N/A

If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe:
The facility has completed routine licensing audits as required by state regulations.

Facility Administrator/Superintendent/Director

Name:	Sharon Evans, Executive Director/ PREA Coordinator		
Email:	EvansSevans@aol.com	**Telephone:**	713-748-9653

Facility PREA Compliance Manager

Name:	Lisa Clay, Program Director		
Email:	shhtxtm@aol.com	**Telephone:**	713-942-8009

Facility Health Service Administrator ☒ N/A

Name:	Click or tap here to enter text.		
Email:	Click or tap here to enter text.	**Telephone:**	Click or tap here to enter text.

Facility Characteristics

Designated Facility Capacity:	22
Current Population of Facility:	11
Average daily population for the past 12 months:	15
Has the facility been over capacity at any point in the past 12 months?	☐ Yes ☒ No
Which population(s) does the facility hold?	☐ Females ☒ Males ☐ Both Females and Males
Age range of population:	10 to17 years of age
Average length of stay or time under supervision	6 months
Facility security levels/resident custody levels	Non secure, minimum

Number of residents admitted to facility during the past 12 months	90
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:	80
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *10 days or more:*	80
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	☐ Yes ☒ No

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

Number of staff currently employed by the facility who may have contact with residents:	20
Number of staff hired by the facility during the past 12 months who may have contact with residents:	8
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	3
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	1

Number of volunteers who have contact with residents, currently authorized to enter the facility:	1
Physical Plant	
Number of buildings: **Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.**	2 RTC Houses
Number of resident housing units: **Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.**	8 bedrooms
Number of single resident cells, rooms, or other enclosures:	0
Number of multiple occupancy cells, rooms, or other enclosures:	8
Number of open bay/dorm housing units:	0
Number of segregation or isolation cells or rooms (for example, administrative, disciplinary, protective custody, etc.):	0
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	☒ Yes ☐ No
Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	☐ Yes ☒ No

Medical and Mental Health Services and Forensic Medical Exams	
Are medical services provided on-site?	☐ Yes ☒ No
Are mental health services provided on-site?	☐ Yes ☒ No

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

Audit Findings

Audit Narrative

Shamar Hope Haven Residential Treatment Center (SHHRTC) headquarters is located at, 2913, Wheeler St in Houston, Texas. SHHRTC is a non-profit 501 © 3 organization governed by a Board of

Directors and managed daily by an experienced on-site management team and direct care staff. The PREA Audit of Shamar Hope Haven Residential Treatment Center (SHHRTC) was conducted over three days on January 8th, 9th, and 10th, 2020. This audit followed the facility's first completed PREA audit on February of 2017. Jerome K. Williams, a Certified Department of Justice Auditor for Juvenile and Adult Facilities conducted that audit. The audit contract was executed on June 6, 2019 between Jerome K. Williams and Shamar Hope Haven Residential Treatment Center's Executive Director.

Throughout the audit, the auditor found the site management team and direct care staff to be responsive to auditor's requests for documentation, scheduling of the interviews, site review and were knowledgeable about the PREA standards. No barriers were encountered in the completion of this audit.

The audit was conducted in three distinct phases: the pre-onsite audit, the onsite audit, and the post-audit phase.

Pre-Audit Phase

Pre-Audit phase methodology included four core activities conducted by this auditor that included:

1. Audit planning and logistics
2. Posting notice of the audit
3. Requested and reviewed the facility's policies, procedures, and other pertinent documentation
4. Conducted research, outreach to advocacy and community organizations

During the pre-onsite phase this auditor communicated by phone with Executive Director Sharon Evans and conducted a "kick-off" call. The phone meeting was conducted on June 24, 2019. During the call the following was discussed:

a. Re-introduction of the PREA audit process to the facility management team members. The discussion surrounded everyone's role in the audit process.
b. Explanation of the PREA Audit process, timelines, purpose of corrective action to improve practices, and the overall goal of a successful final PREA report.
c. Logistics, the need for unimpeded access to the facility and staff during the on-site phase, and document that will be required to complete the audit,
d. Agreement on the best form of communication (e-mail and telephone) and schedule for continued communications.
e. Goals, timeline expectations, and objectives of the PREA audit of Shamar Hope Haven Residential Treatment Center.
f. Notice of audit posting and timeline requirements. Discussion included steps necessary to maintain resident confidentiality in communicating with the auditors.

This auditor followed the "kick off" call meeting with an email summarizing the conversation, reviewed the PREA process map, and the documentation required by the facility before the on-site audit phase.

Shamar Hope Haven's original audit was conducted 3 years ago on June 29th through July 1st, 2016, and they received their Final Report on February 9th, 2017. The facility's management staff were familiar with the process of the "paper audit". Therefore, the overall audit method was the "paper audit" instead of through the PREA On-line Audit System (OAS). During the pre-onsite phase, the facility's management and support staff gathered documents, completed the Pre-Audit Questionnaire (PAQ), and forwarded the information to this auditor via USB drive, certified mail. During this phase, communication between this auditor and the facility's management team, included numerous phone calls, the mailing of the USB drive that included the requested documentation, and numerous e-mails

and text messages. This audit was originally scheduled for November13th-15th, 2019 but the Executive Director requested that this date be rescheduled in January of 2020 due to her conflicting schedule.

This auditor provided SHHRTC with the required notice of audit posting with his name, address, and phone number affixed. Directions on how and where to post the notice of audit were also provided. Proof, in the form of pictures of the audit notice being posted at least 6 weeks in advance of the audit was received from the Executive Director on November 11th, 2019 (8 weeks in advance of the on-site audit). Pictures included proof of posting in both houses, in the common areas, upstairs and downstairs, as well as in the administrative building lobby area, and in the SHHRTC Executive Director's office. During the on-site phase of the audit this auditor did observe and verified that the notice of audit postings was on blue colored paper in the following locations:

a. Administration building lobby area
b. Administration hallway
c. Resident's housing (Truxillo and Wheeler Houses)
d. Dining and common areas of both houses
e. SHHRTC Executive Director's Office

This auditor also conducted a search of the internet for any PREA related incidents on SHHRTC. There were no news articles or law enforcement reports related to sexual abuse or sexual harassment that were found. A review of the agency's website was conducted at www.shamarhopehaven.org , which also included SHHRTC's Zero Tolerance policy, reference was made regarding submitting a 3rd party report but there was no form on the agency's website, just a phone number. The February 9th, 2017 Final PREA Audit Report and subsequent annual reports also were not observed as being posted on the agency's website. The Executive Director indicated as her reason for documents not being on the agency's webpage, that she created the webpage herself and was still learning how to upload document and keep it updated. The agency did have the following numbers listed for reporting anonymously an allegation of sexual abuse or sexual harassment: The Anonymous Tip line (713) 530-3260, the facility's direct number (713) 942-3822 and for reporting directly to Texas Department of Family Protective Services (TDFPS) Child Abuse Hotline at (800) 252-5400. Also listed was the e-mail address of the SHHRTC Executive Director, Sharon Evans for reporting an allegation of sexual abuse and sexual harassment directly.

This auditor contacted the Sexual Assault Resource Center (SARC), the Texas Children Hospital's Child Protective Health Care and the Texas Department of Family Protective Services (TDFPS) Child Abuse Hotline to confirm their role with PREA and knowledge of SHHRTC. Inquiries were made regarding any sexual abuse and sexual harassment allegations, SANE examinations that were conducted during the past three years and specifically in the last 12 months. The SARC, which is a consortium group providing wraparound services through the Children's Hospital for sexual abuse victims confirmed that they had not received any PREA related allegations, have knowledge of any sexual abuse investigations or provided medical services to any SHHRTC resident during the past 12 months. TDFPS hotline representative named Lucy also confirmed that one allegation for sexual abuse was made by SHHRTC in the last 12 months. The Executive Director did provide documentation reflecting that in the last 12 months there have been 1 reported sexual abuse allegations resulting in 1 administrative investigation wherein the findings were Unfounded. During the past 3 years SHHRTC reported zero allegations of sexual abuse and sexual harassment.

Prior to the on-site phase of the audit this auditor reviewed all documentation submitted by the facility via USB drive and email, and he developed an "issue log" of items that deserved additional follow up or

clarification. The issue log instrument was used to identify gaps, missing information or requested clarity regarding information provided on the PREA Audit Questionnaire (PAQ), which was e-mailed to the facility's management team on December 12th, 2019.

Items requested prior to the on-site audit phase of the audit were as follows:

1. Pre-Audit Questionnaire (PAQ). The paper PAQ was discussed at the Kick Off meeting.
2. Description of the agency and facility
3. Organizational Chart
4. PREA related posters, brochures, resident handbooks, and videos in English and Spanish.
5. Staffing Plan
6. Facility schematics
7. Resident, staff, volunteer and contractor rosters including but not limited to;
    a) Complete list of residents
    b) Residents with disabilities
    c) Residents who are Limited in English Proficiency (LEP)
    d) Residents who identify as LGBTQI
    e) Residents in isolation was not applicable because SHHRTC does not use isolation.
    f) Residents in segregated housing was not applicable because SHHRTC does not use segregation.
    g) Residents who reported sexual abuse.
    h) Residents who reported sexual victimization during risk screening.
    i) Staff rosters including staff duties to identify specialized staff.
    j) A list of all contractors that have contact with residents.
    k) A list of all volunteers who have contact with residents.
8. Grievances, allegations of sexual abuse and sexual harassment, all hotline calls made, and incidents from 12 months preceding the audit.
9. Contracts/agreements with other residential facility providers
10. Memorandum of Understanding/Agreement with outside emotional support providers
11. Criminal and administrative investigative reports of sexual abuse and sexual harassment cases (since the last PREA audit was in June of 2016).
12. Investigative Flow Chart
13. Written Coordinated Response Plan.
14. Sexual Abuse Review Team meeting minutes (for the last 12 months)
15. SHHRTC's Zero Tolerance Policy
16. Documents listed in the PREA Compliance Audit Tool Checklist of Policies/Procedures and Other Documents.

This auditor did not receive any confidential correspondence from residents, staff, contractors, or volunteers prior to, during the on-site, or post on-site phase of this audit.

On-Site Phase:

The audit methodology for the on-site phase included:

1. Site/Facility Review
2. Interviews of Staff, Volunteers and Residents
3. Documentation selection and file reviews (staff, volunteers and residents)

On Wednesday January 8th, 2020 the facility census was 11 residents. The on-site phase of the audit was conducted at 2719 Truxillo St, Houston, Texas 77004 (Truxillo House). The Wheeler House was not occupied since the resident population was low. An entrance briefing meeting was attended by the following people at the administrative office 2913, Wheeler St:

a. Sharon Evans, Executive Director
b. Lisa Clay, Program Director
c. Jerome K. Williams, Lead PREA Auditor
d. Courtney Becton, Supervisor

Entrance Meeting:

During the entrance meeting this auditor and the facility management team introduced themselves and discussed the three-phased audit process and what the on-site phase would encompass. The Executive Director/PREA Coordinator explained facility's staff roles, location of files and logs, and the location of where the confidential interviews would occur during the audit. In addition, she provided the following documentation:

a) Current facility resident roster.
b) Current facility staff roster.
c) Current facility staff work schedule.
d) Facility census during the past 12 months.
e) Video: Safeguarding Your Sexual Safety A PREA Orientation Video (English and Spanish)

The Executive Director/PREA Coordinator Sharon Evans reiterated that there had been no sexual abuse and no sexual harassment allegations since the last audit and only one sexual abuse and no sexual harassment allegations in the past 12-month period.

The following external reporting agencies were contacted, since their numbers are listed on the agency's website for reporting sexual abuse and sexual harassment. The purpose of these test calls was to ascertain the process for receipt and forwarding these calls to the appropriate entity for investigation.

- TDFPS Child Abuse Hotline, Lucy (no last name given), Intake Specialist, ID Agent #5304
- The Sexual Assault Resource Center (SARC) which is the consortium group comprised of the Houston Area Women's Center, the Texas Children's Hospital Child Protective Health Care's and the Sexual Assault Nurse Examiner (SANE) Office.

The operator at the Texas Department of Family and Protective Services (TDFPS) Child Abuse Hotline did describe the process for receiving allegations of sexual abuse and sexual harassment and that if it occurred in a residential treatment facility that it would be referred to the Residential Licensing Division for investigations. When contacted by phone, citing confidentiality laws, the Director of the Sexual Assault Resource Center (SARC) would not confirm or deny any information about sexual assault or sexual harassment allegations at SHHRTC. She did confirm that SARC, the consortium group, would provide advocacy, empowerment, and education services free of charge and in a confidential manner to victims of sexual abuse. The Texas Children's Hospital Child Protective Health Care did not confirm nor deny any information about sexual assault or harassment allegations at SHHRTC, but did explain their process. That the Houston Area Women's Center would provide services for sexual abuse and sexual harassment victims and that all referrals to this consortium would be initiated by the Houston Police Department, who would conduct all sexual abuse investigations.

A review of the pre-audit, on-site audit, and post audit document reviews, observations, and interviews confirmed there were zero allegations of sexual abuse and zero allegations of sexual harassment since the last audit. There was one allegation of sexual abuse and zero allegations of sexual harassment in the last 12 months as charted below:

Types of allegation	Total since last audit	Substantiated	Unsubstantiated	Unfounded	Pending investigation
Sexual Abuse	0				
Sexual Harassment	0				
Types of allegations	Total in the last 12 months	Substantiated	Unsubstantiated	Unfounded	Pending Investigation
Sexual Abuse	1			1	
Sexual Harassment	0				

Site Review:

Following the entrance meeting a detailed site review (tour) of the two facility was provided by an assigned direct care staff. The standards used to evaluate SHHRTC facility were those listed in the PREA Compliance Audit Tool – Instructions for PREA Audit Tour. There are three buildings, one is administrative and two that are utilized for residential housing. The facility's schematics provided by facility management did match the residential housing layout toured. While on the site review this auditor had unimpeded access to all areas of the two facilities and the administrative offices. This auditor observed the following areas including, but not limited to;

a) Administration building – 2 offices, 1 kitchen utilized as a storage space for commodities, 1 bathroom, 1 large reception area, and an upstairs area common space utilized for storage. There were no areas of concern regarding the administration building. This building has 4 surveillance cameras. Resident and staff records were observed stored in locking cabinets that were located in administrative secretary's office that had a locking entrance door.
b) Residential housings (Truxillo and Wheeler House)- The Truxillo House, on the first floor has a group room, a common area, a kitchen, a dining area, 2 bathrooms (one for staff usage), several storage closets, 5 cameras and a supervisor's office. Upstairs there are 2 bedrooms with 3 beds, one bedroom with three beds and one bedroom with four beds for a total of 13 beds, 2 bathrooms with showers and several closets for the residents clothing. The Wheeler House, on the first floor has a large common area, 5 cameras, a dining area, a kitchen, a small group room, a bathroom and several closet spaces for storage. Upstairs there is one bedroom with four beds, one bedroom with three beds and one bedroom with two beds for a total of nine beds, two bathrooms with showers and several closets for residents clothing. All of the bathrooms in both houses have doors for privacy when a resident is showering, changing clothes or using the restroom. There were no areas of concern or blind spots in the resident's housing. The residents have unimpeded access to telephones for external reporting of sexual abuse and sexual harassment allegations, to contact the SARC for emotional support and crisis counseling services when applicable and contact information, including the zero tolerance posters were posted near the phone. The area used for resident intake confidential/private screenings are conducted in the supervisor's office, on the first floor, that was away from view

and earshot from the residents. Both the Truxillo and Wheeler Houses were clean and reflected nothing that would be of a concern when considering a resident's sexual safety.

This auditor was able to randomly and informally interview residents and staff as to their knowledge of the PREA standards and the facility's sexual safety practices. Those random residents interviewed, both in structured confidential interviews and during the site review acknowledged the following:

1. Receiving an explanation of the facility's Zero Tolerance Policy and a PREA brochure upon admission.
2. Receiving written information upon admission and watching the PREA video within ten days of their intake.
3. Understanding the facility's Zero Tolerance Policy towards sexual abuse, sexual harassment, and their right to be free from retaliation for reporting sexual abuse or sexual harassment allegations.

There was not an actual intake/admission during the on-site audit. This auditor did ask the intake staff to describe in detail how and where the intake, screening, and classification processes takes place. This auditor did review the intake screening documents utilized and received blank copies for his auditing records. There were no identified items of concern regarding intake privacy, confidentiality, PREA education, or PREA notifications.

Staff Interviews:

SHHRTC provided this auditor with private interview spaces in the administration building as well as in the resident housing area to conduct private and confidential interviews of both the staff and residents. Both spaces (offices) had closing doors and were out of view and earshot from the other staff and residents.

18 of the 20 total staff that were interviewed, 7 were specialized staff, and 11 were randomly selected staff for interviews. The 2 staff not interviewed was the Secretary Assistant and the Contracting Psychologist. The Contracting Psychologist was out of the country at the time of this onsite audit. The random staff interviewed included the following:

a. Male and female random and specialized staff.
b. Day, evening and overnight staff.
c. New staff (hired in 2019) and veteran staff (hired before 2019).

The PREA interview protocols were used to ensure the proper questions were asked during the staff interviews. The number of staff and the correct positions that were interviewed corresponded with the standards listed in the PREA Auditor Handbook. Both specialized and random staff were interviewed. This auditor received a staff roster showing names, tenure, position, and shift assignment. The selection process involved identifying and interviewing specialized staff to match the protocol requirements and selecting as many random staff that would be available on the dates January 8th, 9th and 10th, 2020.

Staff Interviews	Minimum Required	Completed
Agency Head	1	1
Contract Administrator	1	1
PREA Coordinator	1	1
PREA Compliance Manager	1	1
Human Resources	1	1

Random Staff	12	12
Intermediate or higher-level staff responsible for conducting and documenting unannounced rounds	1	1
Education staff – none at SHHRTC	N/A	N/A
	1	Random Staff
Medical Staff – none at SHHRTC	N/A	N/A
Mental Health Staff (he was out of the country)	1	1
Non-medical staff involved in cross gender searches	1	1
Administrative (human resources) staff	1	1
Sexual Assault Forensic Examiner (SAFE) and Sexual Assault Nurse Examiner (SANE) staff	1	1
Volunteers and contractors who have contact with inmates	1	1
Investigative staff-none at SHHRTC	N/A	N/A
Staff who perform screening for risk of victimization and abusiveness	1	1
Staff who supervise inmates in segregated housing-none at SHHRTC	N/A	N/A
Staff on the sexual abuse incident team	1	2
Designated staff member charged with monitoring retaliation – same as Agency Head and Program Director / PREA Coordinator	1	2
First responders – All SHHRTC staff serve as First Responders	1	2
Total Staff Interviews Completed	28	28

SHHRTC's management did provide the required documentation to demonstrate that all staff completed the required PREA trainings to meet every 3 year and 2-year refresher training for this standard's provision.

Resident Interviews:

SHHRTC provided this auditor with a private interview space in Truxillo House, which was out of the view and earshot from other staff and residents to conduct the resident interviews.

11 of the 11 residents present on site during the audit were interviewed. There were 11 residents in their population on each day of the audit. There was no methodology used to select resident since all of the residents were interview. Though there were only one sexual abuse allegations reported during the last 12 months, those residents had been discharged from the facility and could not be interviewed. The resident files reviewed provided documentation that corroborated there were no residents present who met the targeted resident criteria for interviews.

Resident interviews were conducted in compliance with the standards set forth in the PREA Compliance Instrument – Interview Guides for Residents. The breakdown of resident number and type of interviews conducted is below. The resident interviews were conducted in compliance with the standards set forth in the PREA Auditor Handbook. There were no targeted residents interviewed due to none being identified in their population, so in accordance with the Auditor's Handbook, this auditor interviewed all of the residents in order to meet the minimum requirement of interviews for this facility's size.

Total population during on-site interviews 11	Total bed capacity 22
Overall minimum number of resident interviews 10	Number required 10
Minimum number of random resident interviews 5	Number interviewed 11
Minimum number of targeted resident interviews 5	Number interviewed 0 (No residents at the facility meeting this criteria)

Breakdown of required targeted resident interviews	
Residents with a physical disability 1	Number interviewed 0 No resident at the facility meeting this criteria)
Residents who are blind, deaf, or hard of hearing 0	Number interviewed 0 (none at the facility)
Residents that are LEP 0	Number interviewed 0 (none at the facility)
Residents with a cognitive disability 0	Number interviewed 0 (none at the facility)
Residents that identify as lesbian, gay, bisexual, transgender or intersex 1	Number interviewed 0 No residents at the facility meeting this criteria)
Residents in isolation 1	Number interviewed 0 No residents at the facility meeting this criteria)
Residents who reported sexual abuse 1	Number interviewed 0 No residents at the facility meeting this criteria)
Residents who reported sexual victimization during risk screening 1	Number interviewed 0 (No residents at the facility meeting this criteria)
Total Resident Interviews	11

11 of 11 (100%) of the residents interviewed acknowledged receiving PREA information upon intake, that they watched the 'PREA Video," observed displayed in the facility the "Stop Sexual Abuse and Sexual Harassment "posters and have access to the hot line numbers posted in various locations in the houses. The posters included phone numbers and were located within view of the phone the residents use for making phone calls. Poster locations included the dining areas, administrative building lobby, waiting area, in both housing living, dining, group and common areas and in the supervisor's office. Each of the resident interviewed could explain the meaning of the zero-tolerance policy towards sexual abuse and sexual, how to report a sexual abuse and sexual harassment allegation, as well as explain their rights to be free of sexual abuse and sexual harassment while in this facility.

11 of 11 (100%) of the residents interviewed said that they felt safe, sexually safe, and that the staff at SHHRTC cared about their safety.

Resident Files:

This auditor conducted a review of all of the resident files. The file selection methodology were all of the same names of the random residents to be interviewed. The review was conducted using the PREA Audit – Juvenile Facilities Documentation Review – Resident Files/Records template.

Types of information verified in resident files	For Random Residents-11	For Targeted Resident – N/A - there were no targeted residents in the population
PREA Intake Screening w/in 72 hours of admission	11	N/A
Potential Victim, Aggressor, Periodic Reassessment during stay,	11	N/A
PREA Information at Intake	11	N/A
PREA comprehensive education w/in 10 days of Intake	11	N/A

The resident files revealed that all 11 residents had received a PREA screening well within 72 hours of the admission. The usually occurred within 24 hours of admission by the Intake staff. This staff identified as the Intake staff, which is the Program Director/PREA Compliance Manager stated during her interview that she conducts the intake screenings within 24 hours of all residents admitted to the program, more specifically, the juvenile justice youths are assessed with the risk screening instrument to ascertain if they are a potential victim or aggressor as well as having other factors that will could make them vulnerable for sexual abuse and sexual harassment victimization.

Staff Training Files Review:

This auditor conducted a review of all of the staff training files. The file selection methodology were all of the same names of the random and specialized staff to be interviewed. The review was conducted using the PREA Audit – Juvenile Facilities Documentation Review – Employee Files Records template. The review of staff files demonstrated the staff had received PREA training as part of the new employee training, refresher training and annual PREA training. Documentation reviewed demonstrated that SHHRTC had conducted their annual PREA training prior to the on-site audit. The staff PREA training was received from the National Institute of Corrections Training Portal @ www.nicic.org website with correspondence proof documentation. The staff training file documentation also revealed that they received PREA training related to the standard prohibiting cross gender pat down searches, though this is an all-male facility. During the staff interviews the female staff stated they do not conduct cross gender pat down searches of the male residents and have received the cross-gender pat search training. The resident files review demonstrated SHHRTC's compliance with this standard.

Personnel Files Review:

This auditor conducted a review of staff's personnel files. The file selection methodology were the same names as the random staff interviewed. The review was conducted using the PREA Audit – Juvenile Facilities Documentation Review – Employee Files Records template. Required documentation for staff files were reviewed for compliance from 2017 to 2020. The staff files were compliant with the initial and five-year requirement of criminal records check and child abuse registry checks for applicable staff. All 18 staff files had documentation of criminal background checks, mandated reporter training, initial, refresher and annual PREA training. The staff files did not contain any documentation related to institutional reference since none of the eight new hires came from an institutional employer.

Types of information verified information in personnel files	For Specialized staff- 7	For Random Staff -11
Criminal Background Checks every 5 years	7	11
Child Abuse Registry Checks	7	11
Institutional Reference Checks for new hires in last 12 months	0	0
Mandatory PREA Training every 3 years	7	11
Refresher Training every 2 years	0	11
Specialized Training	3	0
Affirmative Duty to Report	7	11

This auditor was unable to find any staff that had been hired in the past three years that listed previous employment at a juvenile or adult institution, therefore SHHRTC was not out of compliance with this

standard's provision. This auditor was not provided with a sample letter that would be sent to an applicant's previous institutional employer who would be seeking to be employed with SHHRTC, that included the applicable institutional reference questions. This auditor recommended that a reference letter with the appropriate institutional questions be created on SHHRTC's letterhead for usage, when applicable, to ensure that SHHRTC is compliant with this provision of the standards.

Investigative Files Review:

SHHRTC PREA Coordinator did report that one sexual abuse investigation that did occur in the last 12 months during her interview. She further stated that there were no sexual harassment allegations or investigations conducted during the last 12 months. The administrative sexual abuse investigation conducted by the Texas Department of Family and Protective Services (TXDFPS), their licensing entity, was completed and the finding was Unfounded.

Types of allegations	Total number since last audit (2/2017)	Substantiated	Unsubstantiated	Unfounded
Sexual Abuse	0			
Sexual Harassment	0			
Types of allegations	Total in last 12 months (1/1/2019-1/1/2020)	Substantiated	Unsubstantiated	Unfounded
Sexual Abuse	1			1
Sexual Harassment	0			

Exit Briefing:

On Friday January 10, 2020 at 10:00am the facility census was still at 11 residents. The on-site phase of the audit was completed at Truxillo House, 2719 Truxillo St, Houston Texas 77004. The exit briefing meeting was held at the administrative office. 2913, Wheeler St and in attendance were the following people:

a. Sharon Evans, Executive Director/PREA Coordinator
b. Lisa Clay, Program Director/Program Compliance Manager
c. Courtney Becton, Supervisor
d. Jerome K. Williams, Certified PREA Auditor

This auditor led the discussion about the preliminary results of the audit including:

- The three-phase process of the PREA audit.
- The three forms of verification (triangulation) used to determine compliance
- The facility's strengths
- The facility's weaknesses
- Any barriers experienced during the audit (which were none).

- The post-audit steps towards completing this audit including the preparation of Interim Report, Corrective Action steps over a 180-day period as applicable and then issuance of a Final Report.

Post Audit Phase:

The audit methodology used and activities in the post audit phase included:

1. This auditor's triangulation of all the information (evidence) received, learned from the interviews, documentation and observations from the first two phases of the audit. The sources of verification were determined through the use of the Auditor Compliance Tool for Juvenile Facilities.
2. This auditor's preparation and writing the SHHRTC Interim PREA Audit Report including corrective actions as applicable.
3. Sending the Interim PREA Audit Report to SHHRTC for corrective action and response within 45 days of the last day of the onsite audit phase. SHHRTC received the Interim Report on February 24th, 2020.
4. Following the receipt of proof documentation to address any and all corrective action concerns, make a compliance audit determination then complete and issue the Final PREA Audit Report within 180 days.

Facility Characteristics

Shamar Hope Haven Residential Treatment Center (SHHRTC) administrative office is located at 2913, Wheeler St in Houston Texas. SHHRTC is a non-profit 501 © 3 organization governed by a Board of Directors and is managed daily by an experienced onsite management team. The Residential Treatment facilities of SHHRTC are located at 2915, Wheeler St (Wheeler House) and at 2719 Truxillo St (Truxillo House), Houston Texas.

Established in the year of 2000, the Shamar Hope Haven Residential Treatment Center (SHHRTC) is a 22 bed (divided between two houses), all male resident facility (ages 8 to 17), non-secure, staff secure level, Title IV (e) residential treatment center located in Houston Texas. Over the past 12 months the facility population has averaged 16 residents. On each day of the on-site audit the facility population was 11 residents. At the time of the on-site audit, SHHRTC had 19 total staff, 1 contractor, and 1 volunteer.

The facility operations are licensed by The Texas Department of Family and Protective Services (TDFPS) located in Houston, Texas. The City of Houston is located in the Coastal Region of the State of Texas. The facility has two residential treatment center homes located in the heart of Houston, Truxillo House at 2719 Truxillo St and Wheeler House, at 2915, Wheeler St, Houston Texas. SHHRTC contracts with Dallas and Bexar County Juvenile Probation Offices as well as with the Texas Department of Family and Protective Services (TXDFPS). Less than 51% or 18% of the residents assigned to this residential treatment facility as of the onsite audit, are low level juvenile justice residents from Dallas and Bexar County Juvenile Probation. The remaining 82% of the residents assigned are placed there by the Texas Department of Health and Human Services' Family and Protective Services division (TXDFPS).

The Shamar Hope Haven Residential Treatment Center also provides the opportunity for each resident to achieve his personal goals by providing specialized programs and trained professionals to provide

the required treatment tailored for each individual resident. Shamar Hope Haven Residential Treatment Programs represents the first step in a resident's ongoing treatment plan. While in the residential treatment program the residents 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 onsite audit there were 11 residents assigned to the facility in totality residing at the Truxillo House. The Wheeler House did not have any residents residing there due to their low population. The residents assigned to this facility attend Yates and or Cullen High schools which is a part of the Houston Independent School District. The Direct Care staff drop off and pick up residents from these schools daily.

It was noticed that when the female staff enter the building, before going upstairs to the bedroom area, they announce themselves, since they are the opposite gender of the residents served. This was also confirmed during the staff and resident interviews. Residents only change their clothing, shower, and use the bathroom in private bathrooms upstairs and are not allowed to be naked in any way in the house. There is no opposite gender viewing during any of the above-mentioned activities and the majority of the times, as revealed during the staff and resident interviews, female staff do not go upstairs during showering, changing of clothing and during bathroom breaks. There is always a male staff working with a female staff who conducts the aforementioned routines. There are 5 surveillance cameras at Shamar Hope Haven Residential Treatment Center Truxillo House as well as in the Wheeler House: One located in the entrance, one in the common area, one in the kitchen and one in the back of the property in both houses. There are 4 surveillance cameras in the administrative building: one at the entrance, one in the lobby/waiting area, one for the doorbell and one in the back of the building. This auditor observed the staff employing good supervision practices throughout the onsite phase of the audit. It was also observed that staff positioning, constantly walking around as well as having two staff on duty reduces the opportunity for residents being unsupervised.

The mission of Shamar Hope Haven Residential Treatment Center (SHHRTC) is to provide a behavioral health and chemical dependency treatment program that exemplifies state of the art technology in the treatment of behavioral health and substance use disorders. They are dedicated to providing research based, culturally and developmentally appropriate therapeutic modalities to their clients and their families. They are committed to excellence regarding their mandate of teaching their clients the skills necessary to live healthy and drug free lives.

Summary of Audit Findings

Standards Exceeded

Number of Standards Exceeded: 0

List of Standards Exceeded: 0

Standards Met

Number of Standards Met: 43

List of Standards Met: 115.311, 312, 313, 315, 316, 317, 318, 321, 322, 331, 332, 333, 334, 335, 341, 342, 351, 352, 353, 354, 361, 362, 363, 364, 365, 366, 367, 368, 371, 372, 373, 376, 377, 378, 381, 382, 383, 386, 387, 388, 389, 401 and 403

Standards Not Met

Number of Standards Not Met: 0

PREVENTION PLANNING

Standard 115.311: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

All Yes/No Questions Must Be Answered by The Auditor to Complete the Report

115.311 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment? ☒ Yes ☐ No

115.311 (b)

- Has the agency employed or designated an upper-level PREA Coordinator? ☒ Yes ☐ No
- Is the PREA Coordinator position in the upper level of the agency hierarchy? ☒ Yes ☐ No
- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities? ☒ Yes ☐ No

115.311 (c)

- If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.) ☒ Yes ☐ No ☐ NA
- Does the PREA compliance manager have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards? (N/A if agency operates only one facility.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

1. Documents reviewed included:

    a. PREA Audit Questionnaire (PAQ)
    b. Shamar Hope Haven Zero Tolerance Policy (SHHRTC)
    c. Acknowledgement of receipt and understanding of PREA policy signed by staff, contractors, and volunteers.
    d. Zero Tolerance posters (including phone numbers to report allegations)
    e. Organizational Chart

2. Interviews included:

    a. Executive Director/PREA Coordinator
    b. Program Director / PREA Compliance Manager

3. Site Review / Observation:

    a. Zero Tolerance Sexual Abuse and Sexual Harassment Postings
    b. Agency's Webpage: www.shamarhopehaven.org.

115.311 (a) SHHRTC has a zero-tolerance policy towards all forms of sexual abuse, and sexual harassment. The purpose of the policy, (pg. 1), states:

> "The purpose of this rule is to establish the SHHRTC's zero-tolerance policy for any form of sexual abuse, sexual harassment, or sexual activity involving resident in the agency's care. This rule also addresses SHHRTC's obligations under federal Prison Rape Elimination Act (PREA) standards for preventing, detecting, and responding to sexual abuse and sexual harassment."

The SHHRTC Zero Tolerance Policy is available to staff, residents, but is not available to members of the public due to not being posted on the agency's web page www.shamarhopehaven.org. The Executive Director/PREA Coordinator indicated that there have been some issues with her webmaster and that she is in the process of revamping her website which will include their Zero Tolerance policy.

Under the general provisions section of SHHRTC's PREA policy it outlines the agency's approach towards preventing, detecting, and responding to sexual abuse and sexual harassment. The facility is not in compliance with this provision.

115.311 (b) The agency Zero Tolerance policy states (pg. 2 a), "SHHRTC a designates upper-level staff member as the agency wide PREA Coordinator" (pg. 2). The agency has a designated PREA Coordinator, which is the Executive Director. She holds an upper level position and has stated during her interview that she has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in her facilities.

115.311 (c) The agency's Zero Tolerance policy states, (pg. 2 b) "SHHRTC a designates a PREA compliance manager at each SHHRTC operated residential facilities. This staff member's duties must be structured to allow sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards". During the interview with the PREA Compliance Manager she stated that she has sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards.

Corrective Action Findings: SHHRTC must thoroughly edit their Zero Tolerance policy and post it on the agency's website so that the public can have access to it and understand the agency's efforts towards preventing, detecting, responding and reporting of sexual abuse and sexual harassment.

Corrective Action Response: SHHRTC did provide to this auditor during the corrective action period an edited Zero Tolerance policy which was also reviewed on the agency's website for public review and access.

This facility is in compliance with this standard.

Standard 115.312: Contracting with other entities for the confinement of residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.312 (a)

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

115.312 (b)

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

1. Documents reviewed included:

    a. PREA Audit Questionnaire (PAQ)
    b. Shamar Hope Haven Zero Tolerance Policy (SHHRTC)
    c. Contracts with Dallas and Bexar Counties
    d. Contract with TX Department Family and Protective Services

2. Interviews included:

    a. Executive Director/ PREA Coordinator
    b. Program Director/PREA Compliance Manager
    c. Agency Contract Administrator

3. Site Review / Observation:

    a. Office where contracts are stored

115.312 (a) SHHRTC is not a public agency but is a non-profit, private agency run facility. SHHRTC stated on the PAQ that the agency has not entered into and or renewed a contract for the confinement of their residents. However, SHHRTC does contract with Dallas and Bexar counties Juvenile Probation Departments as well as with the Texas Department of Health Services Family and Protective Services to provide residential services for their residents. The agency's Executive Director/PREA Coordinator and Program Director confirmed in their interviews that the agency does not contract for the confinement of their residents with other entities but do contract with Dallas and Bexar counties Juvenile Probation Departments as well as with the Texas Department of Health Services Family and Protective Services (TXDFPS) to provide residential services for their residents. SHHRTC did provide this auditor with copies of the contracts with TXDFPS, Dallas and Bexar counties. This facility is in compliance with this provision.

115.312 (b) SHHRTC contracts with Dallas and Bexar counties as well as with the Texas Department of Health Services Family and Protective Services to provide residential services for their residents. A review of the contracts with the three Juvenile Probation Departments (Dallas and Bexar counties), they do state that SHHRTC will "comply with the Final Rule of the Prison Rape Elimination Act (PREA) of June 20, 2012 and with all applicable PREA standards". This was confirmed during the interview of the Agency Contract Administrator, which is the Executive Director/PREA Coordinator. These three county Juvenile Probation Department also have a clause in their contracts for monitoring SHHRTC to ensure that they are in compliance with the PREA standards during the contract period. The contract with TXDFPS does not require SHHRTC to comply with the PREA standards because the youth placed in this facility comes from the community (child protective services) who have not been adjudicated in the criminal justice system. This facility is in compliance with this provision.

Corrective Action Findings: None.

This facility is in compliance with this standard.

Standard 115.313: Supervision and monitoring

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.313 (a)

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

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Generally accepted juvenile detention and correctional/secure residential practices? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any judicial findings of inadequacy? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any findings of inadequacy from Federal investigative agencies? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any findings of inadequacy from internal or external oversight bodies? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)? ☒ Yes ☐ No

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

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The number and placement of supervisory staff? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Institution programs occurring on a particular shift? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any applicable State or local laws, regulations, or standards? ☒ Yes ☐ No

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

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors? ☒ Yes ☐ No

115.313 (b)

- Does the agency comply with the staffing plan except during limited and discrete exigent circumstances? ☒ Yes ☐ No

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

115.313 (c)

- Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of "secure".)
  ☐ Yes ☐ No ☒ NA

- Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of "secure".) ☐ Yes ☐ No ☒ NA

- Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of "secure".) ☐ Yes ☐ No ☒ NA

- Does the facility ensure only security staff are included when calculating these ratios? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of "secure".) ☐ Yes ☐ No ☒ NA

- Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph? ☒ Yes ☐ No

115.313 (d)

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

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns? ☒ Yes ☐ No

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

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan? ☒ Yes ☐ No

115.313 (e)

- Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities) ☐ Yes ☐ No ☒ NA

- Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities) ☐ Yes ☐ No ☒ NA

- Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? (N/A for non-secure facilities) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

1. Documents reviewed included:

    a. PREA Audit Questionnaire (PAQ)
    b. SHHRTC Zero Tolerance Policy
    c. SHHRTC Staffing Assessment and Staffing Plan- need cleaning up
    d. SHHRTC Unannounced Rounds Logs
    e. SHHRTC Facility Schematics of Truxillo and Wheeler House
    f. Memorandum for Supervision and Monitoring review of Staffing Plan

2. Interviews included

    a. Random residents
    b. Random staff
    c. Executive Director/ PREA Coordinator
    d. Program Director/PREA Compliance Manager

3. Site Review / Observation:

    b. Staff to resident ratio observations throughout onsite phase.

115.313 (a) SHHRTC's Zero Tolerance Policy, (pg. 3), states that "SHHRTC develops and implements a written staffing plan to provide adequate levels of staffing or video monitoring (if applicable) to protect resident against sexual abuse. (page 3, (3), (A), (I))". The PAQ reflected no instances of a deviation from the planned staff to resident ratio, which is 1 to 5 during waking hours and 1 to 12 during sleeping hours. SHHRTC is a non-secure residential facility, whose primary resident population are from the TXDFPS (child protective services) and by PREA definition, not required to be PREA audited. He

Executive Director/PREA Coordinator has elected to have SHHRTC PREA audited once again because of her desire to receive and provide services to juvenile justice youth from Dallas, Harris and Bexar county's Juvenile Probation Departments. With this being said, SHHRTC currently have 6 or 54% of juvenile justice residents in their population as of the onsite audit.

SHHRTC's staffing plan was provided during the pre-audit phase and reviewed by this auditor. Based on the average resident population by month for the past 12 months, which is 16 and taking into consideration a low staff turnover rate in the past 12 months, this auditor found no obvious reason to believe there had been any deviation from the facility's staffing plan. TXDFPS contractual agreement requires that SHHRTC maintain a 1 to 5/1 to 12 staff/resident ratio. This is well below the PREA requirement of staff to resident ratio. SHHRTC does use surveillance cameras to aid the facility staff in monitoring the residents in Truxillo and Wheeler House. There are 5 cameras in each residential house: At the front entrances, in the dining rooms, in the common areas, the group rooms and at the rear of each buildings. Through the staff interviews, this auditor found no reports of short staffing or ratio deviations in the daily monitoring and supervision of the residents. There were no findings of judicial inadequacy, inadequacies from a Federal investigative agency, or inadequacies from an internal or external oversight body (e.g. Dallas County Juvenile Probation or TXDFPS Regulatory agency). During the site review this auditor did not identified any blind spots or areas in the facility where staff or residents may be isolated.

Because of the contracts with TXDFPS and the juvenile probation departments, this staffing plan and video monitoring consideration does take into account the composition of the population, which as of the onsite audit is 46% TXDFPS residents and 56% juvenile justice residents. The staffing plan also takes into consideration the following:

- The number and placement of supervisory staff
- Employees work shifts,
- Applicable state, local laws, regulations and standards
- Prevalence of substantiated and unsubstantiated incidents of sexual abuse
- Other relevant factors

Further evidence of compliance with this standard was ascertained during the interviews of the Executive Director/PREA Coordinator and the Program Director/PREA Compliance Manager. Both these individuals confirmed that SHHRTC's staffing plan was developed to ensure that adequate staffing is maintained in the facilities to protect the residents, and that the video monitoring is employed, as part of the staffing plan, further detect, prevent and protect residents against sexual abuse.

115.313 (b) The SHHRTC Zero Tolerance Policy as well as their contracts with Dallas and Bexar, County Juvenile Probation Departments and TXDFPS requires constant supervision and monitoring of the residents while in the facilities. The policy states that the facility maintains a 1 to 5 ratio during waking hours and a 1 to 12 staff ratio during sleeping hours except during limited or discrete exigent circumstances. Onsite observations by this auditor, during the audit, exceeded the established written ratios. Observed ratios were 1:4, 1:3, 1:2, and 1:1. The Executive Director/PREA Coordinator stated during her interview that there have been no deviations from the ratio in the last 12 months.

115.313 (c) SHHRTC facility roster showed 20 full time staff employed of which 13 are direct care staff, 1 is a supervisor, 2 are program staff, and 4 are administrative office staff. The resident roster provided during the pre-audit phase reflected their current population of 11 residents. This auditor found no evidence nor was there a report of the staff to resident ratio deviating from the planned ratio of 1:5 daytime. This auditor found no evidence nor was there a report of the staff to resident ratio deviating from the planned ratio of 1:12 at nighttime. SHHRTC did not document any deviations from the staffing ratio of any limited or discrete exigent circumstances. SHHRTC is a non-secure facility and calculating

the ratios are not applicable SHHRTC is obligated by TXDFPS regulations and contractual agreement to maintain a 1 to 5 daytime and 1 to 12 nighttime staff to resident ratio.

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

- Prevailing staffing patterns
- Deployment of video monitoring systems and other technologies
- Available resources needed to adhere to the staffing plan

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

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

SHHRTC does have a policy, (pg. 3), that prohibits staff from alerting other staff of an unannounced round being made by an intermediate and or higher-level staff member.

The facility is in compliance with this standard.

Corrective Action Findings: None

Standard 115.315: Limits to cross-gender viewing and searches

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.315 (a)

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

115.315 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances? ☒ Yes ☐ No ☐ NA

115.315 (c)

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

- Does the facility document all cross-gender pat-down searches? ☒ Yes ☐ No

115.315 (d)

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

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

- Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit? ☒ Yes ☐ No

- In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units) ☒ Yes ☐ No ☐ NA

115.315 (e)

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

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

115.315 (f)

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

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. SHHRTC Zero Tolerance Policy
c. Staff training files
d. National Institute of Corrections (NIC) Cross gender Pat Search curriculum
e. Search logs

Interviews included:

a. Random residents
b. Random staff
c. Non-security staff involved in cross gender searches
d. First Responder, security and non-security staff

Site Review / Observation:

e. Residential housings (Truxillo and Wheeler House)
f. Administrative areas

115.315 (a): SHHRTC Zero Tolerance policy, (pg. 3), states “that they will maintain restrictions and limitations on cross-gender searches and shall always refrain from conducting cross gender strip or cross gender visual body cavity searches, except in exigent circumstances or by a medical practitioner”. This is an all-male facility and all staff, including female, have been trained on how to conduct a cross gender pat search.

The random staff training files and interviews revealed that they were trained on how to conduct a cross gender pat down search. The 2 of the random female direct care staff interviewed stated that female staff do not conduct pat down searches on the male residents at any time. They further indicated that there has not been an exigent circumstance in the last 12 months to warrant such a cross gender pat down search.

115.315 (b): SHHRTC is an all-male facility and interviews conducted with all 11 the random staff, inclusive of the female direct care staff, revealed that the female staff have not conducted cross gender pat down searches in non-exigent circumstances in the last 12 months.

115.315 (c): SHHRTC Zero Tolerance policy (pg. 3) states "that they will maintain restrictions and limitations on cross-gender searches and shall always refrain from conducting cross gender strip or cross gender visual body cavity searches, except in exigent circumstances or by a medical practitioner". SHHRTC Executive Director/PREA Coordinator stated during her interview that they do not conduct cross gender strip searches and cross gender visual body cavity searches in her facilities. Therefore, there is no need to document these protocols.

115.315 (d): SHHRTC Zero Tolerance policy, (pg. 3) states that "staffing patterns and physical barriers are implemented to enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances". The facility's bathrooms are designed to prohibit cross gender viewing of resident performing such personal actions because of having locking doors to avoid staff or other residents from viewing them in both locations. The facility schematic shows the single resident bathroom/shower for Truxillo and Wheeler house as being on the 2nd floor of the houses. This auditor confirmed the schematic plans of these areas during the site review.

SHHRTC requires staff of the opposite gender to announce their presence when entering the Residential housings and before going upstairs to the bedroom and bathroom areas in each house. During the interviews with the all 12 of the random staff they all confirmed that the female staff do make an announcement saying: Female staff is coming upstairs, before they proceed to the bedroom areas. The random male staff further stated that they do not allow the female staff to come upstairs during shower and restroom routines of the residents. This statement was also confirmed during the random resident interviews. 11 out of 11 random residents interviewed stated that the female staff are not allowed upstairs during shower, restroom routines and that they do announce their presence before coming upstairs to the bedroom areas of the residents.

This auditor did observe a female staff announce her presence when seeking to go upstairs to the bedroom area of the residents in Truxillo house even though there was a male staff upstairs.

115.315 (e) SHHRTC Zero Tolerance Policy, (pg. 4) states that "staff do not search or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status. The status may be determined during conversations with the resident, by reviewing medical records, or as part of a broader medical examination conducted in private by a medical practitioner". The Executive Director/PREA Coordinator stated during her interview that this policy is adhered to by her staff and that there have been no transgender or intersex residents in her population in the last 12 months.

115.315 (f) SHHRTC did provide evidence that all of the direct care staff have been train on how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs including how to conduct searches of transgender and intersex residents in a professional and respectful manner. A review of the employees training records revealed that all staff have received cross gender pat search training, searches of transgender and intersex residents followed by an acknowledgement statement and signature on the training roster. This is an all-male facility.

This facility is in compliance with this standard.

Corrective Action: None.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.316 (a)

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

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

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

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

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

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

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

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

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

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

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

115.316 (b)

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

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

115.316 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. SHHRTC Zero Tolerance Policy
c. Intake Screening Forms
d. Resident Orientation Handbook (English and Spanish)
e. PREA Zero Tolerance Posters
f. Houston Independent School District Agreement (HISD)

Interviews included:

a. Random residents
b. Random staff

c. PREA Compliance Manager
d. First Responder, security and non-security staff

Site Review / Observation:

a. Residential housing postings
b. Administrative Building postings

115.316 (a) The SHHRTC Zero Tolerance Policy, (pg. 5) states that "SHHRTC will take reasonable steps to ensure meaningful access to all aspects of the agency's efforts prevent, detect, and respond to sexual abuse and sexual harassment residents who are:

- Deaf or hard of hearing
- Blind or have low vision
- Limited English Proficient
- Intellectually disabled
- Psychiatric disabled
- Speech disability

And that appropriate steps will be taken to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's effort to prevent, detect, and respond to sexual abuse and sexual harassment.

SHHRTC has taken steps to ensure that there is effective communication with residents who are:

- Deaf or hard of hearing
- Blind or have low vision
- Limited English Proficient
- Intellectually disabled
- Psychiatric disabled
- Speech disability

By entering into an agreement with the Houston Independent School District (HISD) to provide these services to the residents in their facility. SHHRTC also has access to the language line, when needed, for residents requiring interpreting in another language. The Executive Director/PREA Coordinator indicated during her interview that HISD will and does provide these services to SHHRTC residents as needed. She did not provide a copy of the memorandum of agreement from HISD. This facility is not in compliance with this provision.

115.316. (b) SHHRTC Program Director/PREA Compliance Manager did indicate during her interview that they will do whatever is necessary to ensure the residents understand the PREA standards and their rights. They will utilize, when necessary, staff as translators, the language line and HISD's special education resources for residents who may be deaf, speech impaired, limited in English proficiency, blind and or low vision or who are psychiatric or are intellectually impaired. At the time of the audit, nor in the past 12 months, did the facility have any resident who were assessed as needing interpreting services, had a disability or were limited English proficient. This determination was made based on interviews of the Intake staff, program staff, and a review of the resident files.

115.316 (c) SHHRTC Zero Tolerance policy states, (pg. 5), that SHHRTC does not use other residents to interpret, read, or otherwise assist except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise safety, the performance of first responder duties, or

an investigation". The Executive Director/PREA Coordinator and Intake staff stated during their interviews that SHHRTC does not use resident interpreters or assistants for reporting sexual abuse and sexual harassment allegations in the last 12 months. During the random staff interviews all 12 of the staff indicated that SHHRTC has not utilized resident interpreters or assistants for reporting sexual abuse and sexual harassment allegations.

Corrective Action: SHHRTC must obtain a memorandum of Understanding from HISD indicating that they will provide services to residents who are deaf or hard of hearing, blind or have low vision, Limited English Proficient, intellectually disabled, psychiatric disabled and who have a speech disability. SHHRTC must also provide an agreement with the Language Line for providing interpreters when needed, in order to be in compliance with this standard.

Corrective Action Response: SHHRTC did provide to this this auditor a copy of the Memorandum of Understanding from HISD indicating that they will provide services to residents who are deaf or hard of hearing, blind or who have low vision, Limited English Proficient, intellectually disabled, psychiatric disabled and who have a speech disability. SHHRTC also provided a copy of the entered agreement with the Language Line for providing interpreters when needed, in order to be in compliance with this standard.

This facility is in compliance with this standard.

Standard 115.317: Hiring and promotion decisions

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.317 (a)

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

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

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

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

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

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

115.317 (b)

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

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

115.317 (c)

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

- Before hiring new employees, who may have contact with residents, does the agency consult any child abuse registry maintained by the State or locality in which the employee would work? ☒ Yes ☐ No

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

115.317 (d)

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

- Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

115.317 (e)

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

115.317 (f)

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

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

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

115.317 (g)

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

115.317 (h)

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. SHHRTC Zero Tolerance Policy
c. Criminal Records and Child Abuse Registry Check Documentation
d. Employment Application
e. Employee PREA Self-Disclosure Forms
f. Staff Training Records
g. Resident Orientation Handbook (English and Spanish)
h. PREA Sexual Abuse and Sexual Harassment Posters

Interviews included:

a. Executive Director / PREA Coordinator
b. Human Resources
c. Program Director/PREA Compliance Manager

Site Review / Observation:

a. None to observe.

115.317 (a). SHHRTC Zero Tolerance policy, (pg.5), states that "SHHRTC does not hire or promote anyone who may have contact with resident and does not use services of any contractor who may have contact with the person if the person:

> (I) has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution;
> (ii) who have been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, of if the victim did not consent or was unable to consent or refuse.
> (iii) Enlist the services of any contractor who has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution; or who have been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, of if the victim did not consent or was unable to consent or refuse.
> (iv) Enlist the services of any contractor who has been civilly or administratively adjudicated or engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse.

The Human Resource staff confirmed during her interview that SHHRTC has not hired, promoted, or contracted with anyone who meets the criteria listed above in (I) through (iv). A review of employee files revealed that there was no documented evidence of SHHRTC hiring, promoting or utilizing the services of any contractors during the last 12 months as stated above.

115.317 (b) SHHRTC Zero Tolerance Policy, (pg.5), states that "For any person who may have contact with juveniles, SHHRTC considers any incidents of sexual harassment in determining whether to hire, promote, or contract for services". The Human Resource staff indicated during her interview that a thorough criminal background check, pre-employment reference checks, and a child abuse registry checks are conducted before an applicant or contractor is offered a position. She further stated that a "hit" would automatically come to her via email from the Department of Public Safety (DPS) if any of her current employees are arrested or come in contact with law enforcement. A review of the employee and contractor files revealed no documented evidence of SHHRTC hiring, promoting or procuring the services of a contractor in violation of this provision.

115.317 (c) SHHRTC Zero Tolerance Policy, (pg.6) states that "before hiring new employees who may have contact with resident, SHHRTC Executive Director will:

(i) Performs a criminal background records check
(ii) Consults the child abuse registry maintained by Texas Department of Family and Protective Services (DFPS); and
(iii) Makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse.

A review of the employee files revealed that SHHRTC have been conducting background checks and completing reference checks, however they did not have documented proof of attempts to ask previous institutional employer information regarding substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. During the interview with

the Human Resource staff she stated 4 of the last 8 news hires came from institutional facilities. During the employee file review, it was ascertained that no institutional reference check had been performed on these 4 new hires. This facility is not in compliance with this provision.

During the onsite audit this auditor provided a sample letter to send to a prior institutional employer for information substantiated related incidents and resignations. Further review of the employee files revealed that documented child abuse registry checks through the Department of Health Services (DHS) have been conducted on all employees in the last 12 months

115.317 (d) SHHRTC Zero Tolerance Policy (pg.6), states that "before enlisting the services of a contractor who may have contact with residents, the Executive Director will:

(i) Performs a criminal background records check
(ii) Consults the child abuse registry maintained by Texas Department of Family and Protective Services (DFPS);

Further review of the contractor file revealed that documented child abuse registry checks through the Department of Health Services (DHS) had been conducted in the last 12 months

115.317 (e) SHHRTC does conduct criminal background checks every five years of current employees and on contractors who may have contact with residents. This was evidenced through the employee file review of the staff and contractor and confirmed in interviews with the Executive Director and Human Resource staff.

115.317 (f) SHHRTC Zero Tolerance Policy, (pg. 6) does" asks applicants and employees who may have contact with youth directly about previous misconduct described in subparagraph (A) of this paragraph in written applications or interviews for hiring or promotion and in any interviews or written self-evaluations conducted as part of reviews of current employees. SHHRTC employees have a continuing affirmative duty to disclose any such misconduct. Material omissions regarding such misconduct or the provision of materially false information is grounds for termination of employment". SHHRTC did provide during the pre-audit phase a completed "PREA Self-Disclosure" document on each employee as part of their continuing affirmative duty to disclose any such misconduct.

115.317 (g) SHHRTC Zero Tolerance Policy, (pg. 6), does indicates" Material omissions regarding such misconduct or the provision of materially false information is grounds for termination of employment". The Human Resource staff did indicate during her interview that all staff and contractors have been informed of this policy and that there have been no violations of this policy in the last 12 months.

115.317 (h) SHHRTC Zero Tolerance Policy, (pg. 6), does state, "that unless prohibited by law, SHHRTC provides information on substantiated allegations of sexual abuse or sexual harassment involving former employees upon receiving a request from an institutional employer for whom the former employee has applied to work". During the interview with the Human Resource staff, she indicated that such disclosure would not be an issue because most reference checks are accompanied by written permission to disclose information from the subject of the reference check. At the time of the onsite audit the SHHRTC Human Resource staff indicated that she had not received any requests for information from a juvenile institution on a current staff. She also indicated that she has not requested information on any of the 8 new hires in 2019. During an interview with 3 random and 1 specialized staff they indicated either being previously being employed or are currently employed with a juvenile institutional employer. Upon review of these 4 employee files it was ascertained that no institutional reference check letter was in their file. This facility is not in compliance with this provision of the standard.

Corrective Action: SHHRTC must develop a sample letter to send to a prior institutional employer for information on substantiated related incidents and resignations of a potential hire for future references and usage in order to be in compliance with this standard.

Corrective Action Response: SHHRTC did provide to this auditor a sample letter that would be send to a prior institutional employer for information on substantiated related sexual abuse incidents and resignations of a potential hire for future employment.

This facility is in compliance with this standard.

Standard 115.318: Upgrades to facilities and technologies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.318 (a)

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

115.318 (b)

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. Facility Schematics (Truxillo and Wheeler House)

Interviews included:

a. Program Director/PREA Compliance Manager
b. Executive Director/PREA Coordinator

Site Review / Observation:

a. Observations during the site review of the administrative building and the two residential housing locations

115.318 (a) SHHRTC Zero Tolerance Policy, (pg.5) states that "When designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, SHHRTC will consider the effect of the design, acquisition, expansion, or modification on the agency's ability to protect residents from sexual abuse". The Executive Director/PREA Coordinator and the Program Director/PREA Compliance Manager indicated in their interviews that there have not been any expansion or modification of existing facilities to consider the effect of the design, acquisition, expansion, or modification upon SHHRTC's ability to protect residents from sexual abuse.

115.318 (b) SHHRTC Zero Tolerance Policy, (pg.6) states that "When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, SHHRTC considers how such technology may enhance the agency's ability to protect youth from sexual abuse". During the site review this auditor notices that SHHRTC has installed 5 cameras in the Truxillo and Wheeler Houses to enhance the agency's ability to protect residents from sexual abuse. One in the entrance, one in the dining room, one in the group room, one in the common area and one at the rear of the building. This installation location is the same for both houses. Four cameras have been installed in the Administrative building, one at the entrance, one in the lobby/waiting area, one in the Executive Director's office and one at the rear of the building. No other cameras or electronic surveillance systems have been installed since the last audit nor in the last 12 months.

This facility is in compliance with this standard.

Corrective Action Findings: None

RESPONSIVE PLANNING

Standard 115.321: Evidence protocol and forensic medical examinations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.321 (a)

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

115.321 (b)

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

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

115.321 (c)

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

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

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

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

115.321 (d)

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

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

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

115.321 (e)

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

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

115.321 (f)

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

115.321 (g)

- Auditor is not required to audit this provision.

115.321 (h)

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. Shamar Hope Haven RTC Zero Tolerance Policy
c. Memorandum of Understanding from Harris County Sheriff
d. Memorandum of Understanding Sexual Assault Recovery Center (SARC)

Interviews included:

a. Program Director/PREA Compliance Manager
b. Human Resources
c. Agency Contract Administrator
d. SAFE/SANE Nurse at Texas Children's Hospital Child Protective Health Care Unit: SARC (Sexual Assault Resource Center - 24-hour hotline and services)
e. Random staff interviews
f. Random resident interviews

Site Review / Observation:

a. Facility postings
b. Brochures available to residents

115.321 (a) SHHRTC is not responsible for investigating allegations of sexual abuse and sexual harassment. The Harris County Sheriff Department conducts the criminal investigations and the Texas Department of Family and Protective Services Licensing Division conducts the administrative investigations.

115.321 (b) SHHRTC is not responsible for investigating allegations of sexual abuse and sexual harassment. The Harris County Sheriff Department conducts the criminal investigations and the Texas Department of Family and Protective Services Licensing Division conducts the administrative investigations.

115.321 (c) SHHRTC Zero Tolerance Policy, (pg. 6) states that "when evidentiarily or medically appropriate, SHHRTC transports residents who experience sexual abuse to a hospital , clinic or emergency room that can provide for medical examination by a Sexual Assault Nurse Examiner (SANE) and that such medical examinations are provided at no financial cost to the resident".

The Executive Director/PREA Coordinator stated during her interview that in the event of a sexual abuse allegation, SHHRTC calls the Houston Police Department for criminal investigation and they would take the resident to Texas Children's Hospital for the SANE examination. The Texas Children's Hospital services include Sexual Assault and Violence Response and Child Protective Health Care Team. During the interview with the SANE Nurse, she referred this auditor to the hospital web site where under the "Forensic Medicine" tab the following mission statement was found: "The Child Protective Heath Care Team at Texas Children's Hospital provides compassionate, sensitive, timely care for victims of violent crimes, child abuse and neglect."

The SANE Nurse explained that she was the lead SANE nurse, but in her absence another forensic nurse would be on duty. She explained it was hospital practice to have a forensic nurse available 24 hours a day. The hospital web site explains, "when sexual assault has occurred, a forensic nurse who is a sexual assault nurse examiner (SANE) will provide nonjudgmental, compassionate care to the patient. SANEs are registered nurses who have had specialized training in the comprehensive medical forensic care of patients who have experienced sexual assault. They are certified by the Texas Office of the Attorney General."

The Executive Director/PREA Coordinator further indicated during her interview that there have been no referrals of sexual abuse victims to the Texas Children's Hospital in the last 12 months. A review of the resident files corroborated this assertion.

115.321 (d) SHHRTC Zero Tolerance Policy, (pg. 6) states that SHHRTC seeks to secure victim advocacy services from a local rape crisis center". Rape Crises Center services are provided free of charge by the Sexual Assault Resource Center (SARC) a community-based organization that provide emotional support, counseling and advocacy services. The Executive Director/PREA Coordinator did provide a Memorandum of Understanding between SHHRTC and the SARC to corroborate the services to be offered for a sexual abuse victim.

According to the SARC representative, once a sexual abuse victim (resident) is referred to the Texas Children's Hospital they will receive "wraparound" services e.g. SANE examination, victim advocacy, emotional support and counseling service through this established consortium network. The Program Director/PREA Compliance Manager indicated during her interview that a victim advocate is always made available to victims of sexual abuse either by SHHRTC or by a qualified staff member. She further indicated that there have been no referrals of sexual abuse victims to the Texas Children's Hospital in the last 12 months. A review of the resident files corroborated this assertion.

115.321 (e) SHHRTC Executive Director/PREA Coordinator indicated during her interview that at a sexual abuse victim requests a qualified staff member would accompany the resident through the forensic medical examination process and investigatory interviews. The Program Director/PREA Compliance Manager is a qualified mental health counselor on duty 5 days a week to provide advocacy, crisis intervention counseling and emotional support services. However, the Texas Children's Hospital services through the SARC remains available 24/7 to support victims through the forensic medical examination process and investigatory interview process also. These services include the forensic examination, emotional support, crises intervention, information, and referrals. During the phone interview with the SANE Nurse at the Texas Children's Hospital, she confirmed that she is qualified to conduct Sexual Assault Medical Forensic Examinations (SANE) for obtaining usable evidence for administrative or criminal investigations.

115.321 (f) SHHRTC Executive Director/PREA Coordinator did provide this auditor with a Memorandum of Understanding between SHHRTC and Harris County Sheriff Department dated December 31st, 2019 confirming that they will conduct all criminal investigations. As of this report, Harris County Sheriff Department have not returned the signed copy of this understanding.

1155.321 (g) Auditor is not required to audit this provision.

115.321. (h) The Executive Director/PREA Coordinator and the Program Director/PREA Compliance Manager both stated during their interviews that SHHRTC would always make a victim advocate from the SARC available to victims.

This facility is in compliance with this standard.

Corrective Action Findings: None

Standard 115.322: Policies to ensure referrals of allegations for investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.322 (a)

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

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

115.322 (b)

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

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

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

115.322 (c)

- If a separate entity is responsible for conducting criminal investigations, does the policy describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for criminal investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

115.322 (d)

- Auditor is not required to audit this provision.

115.322 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. Shamar Hope Haven RTC Zero Tolerance Policy
c. Memorandum of Understanding from Harris County Sheriff Department
d. Memorandum of understanding from the Sexual Assault Recovery Center (SARC)
e. Staff Training Files

Interviews included:

a. Program Director / PREA Compliance Manager
b. Executive Director/ PREA Coordinator
c. SAFE/SANE Nurse at Texas Children's Hospital
d. SARC (Sexual Assault Resource Center - 24-hour hotline and services)
e. Random staff interviews
f. Random resident interviews

Site Review / Observation:

c. Facility postings
d. Brochures available to residents

e. Facility's website: www.shamrhopehaven.org

115.322 (a) The SHHRTC Zero Tolerance Policy, (pg. 6) states that "that all allegations of sexual abuse and sexual harassment are reported to and investigated by the Texas Department of Family and Protective Services (TDFPS) Licensing Division for administrative investigations and the Harris County Sheriff Department for criminal investigations". During interview with Agent #5304 of TDFPS confirmed there were one reported administrative sexual abuse investigation during the past 12 months. Upon conducting a file review this auditor reviewed the email notification dated 8/6/19, sent to SHHRTC Executive Director, indicating that the sexual abuse allegation made was Unfounded. SHHRTC Executive Director/PREA Coordinator report zero criminal investigations for sexual abuse in the last 12 months.

115.322 (b) SHHRTC Zero Tolerance Policy, (pg. 6) states that "all allegations of sexual abuse and sexual harassment are assigned to the appropriate agency, Texas Department of Family and Protective Service (TXDFPS) Licensing Division for administrative investigations and to the Harris County Sheriff Department for criminal investigation".

Since the last audit in 2016, SHHRTC Zero Tolerance Policy was finalized but was not posted on the agency web page. The Zero Tolerance Policy is in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an appropriate agency with the legal authority to conduct criminal investigations. Currently, this policy is made available in the administrative office of SHHRTC in the lobby area and upon request.

115.322 (c) SHHRTC Zero Tolerance Policy, (pg. 6) states that "all allegations of sexual abuse and sexual harassment are assigned to the appropriate agency, Texas Department of Family and Protective Service (TXDFPS) Licensing Division for administrative investigations and to the Harris County Sheriff Department for criminal investigation".

115.322 (d) The auditor is not required to audit this provision.

115.322 (e) Auditor is not required to audit this provision.

This facility is in compliance with this standard.

Corrective Action Findings: None

TRAINING AND EDUCATION

Standard 115.331: Employee training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.331 (a)

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

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

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

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

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

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

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

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

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

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

- Does the agency train all employees who may have contact with residents on relevant laws regarding the applicable age of consent? ☒ Yes ☐ No

115.331 (b)

- Is such training tailored to the unique needs and attributes of residents of juvenile facilities? ☒ Yes ☐ No

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

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

115.331 (c)

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

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

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

115.331 (d)

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. Shamar Hope Haven RTC Zero Tolerance Policy
c. Employee Training File Documentation (training rosters and certificates)
d. Volunteer and Contractor's Files Documentation (training rosters and certificates)

Interviews included:

a. Executive Director / PREA Coordinator
b. Program Director/PREA Compliance Manager
c. Random Staff
d. Intermediate and Higher-Level staff
e. Contractors and Volunteers

Site Review / Observations:

a. Employee, Volunteer and Contractors files and training records

115.331 (a) The SHHRTC Zero Tolerance Policy, (pg. 7) states that it will provide PREA related training to all its employees who may have contact with resident". SHHRTC training addresses:

- How to fulfill their PREA responsibilities under SHHRTC policies and procedures.

- Residents right to be free from sexual abuse and sexual harassment.
- The right of residents and employees to be free from sexual abuse and harassment.
- The right of residents to be free from retaliation for reporting sexual abuse and harassment
- The dynamics of sexual abuse and sexual harassment in juvenile facilities.
- The common reactions of juvenile victims of sexual abuse and harassment.
- How to detect and respond to signs of threatened and actual sexual abuse.
- How to avoid inappropriate relationships with residents.
- How to communicate effectively and professionally with residents including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents.
- How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities.
- Relevant laws regarding the applicable age of consent.

It was ascertained during the interviews conducted with the 12 random staff that the PREA training they received cover the above 11 points as required. SHHRTC utilizes the National Institute of Corrections (NIC) training titled “PREA: Your role in Responding to Sexual abuse” when training their staff as well as the 8-hour PREA Employee Training from the PREA Resource Center.

115.331 (b) The Executive Director/PREA Coordinator and the Compliance Manager states that the PREA training is tailored to the unique needs and attributes a gender of the residents at the facility. This is also corroborated from the PAQ response. SHHRTC is a single gender (all-male) facility and the staff of the opposite gender receive the same training regardless of what Residential housing they are assigned to. Training documentation reviewed and received by this auditor supports SHHRTC compliance with this standard. The training is provided during new employee orientation training and during the annual refresher training.

115.331 (c) SHHRTC Program Director/PREA Compliance Manager did provide to this auditor during the pre-audit phase written verification all of the staff received the annual in classroom PREA training June of 2019 and they all signed an acknowledgement statement that they understood their PREA responsibilities. The Executive Director/PREA Coordinator indicated during her interview that all staff receives refresher PREA training on an annual basis and annually. Each staff receives training on the Zero Tolerance policy. This also was confirmed when reviewing the employee training files.

115.331 (d) The SHHRTC Executive Director/PREA Coordinator did provided to this auditor training documentation where the staff being trained acknowledged with their signature that they understand the training they received. During the interviews with all of the staff it was ascertained that they had a good understanding of 115.331 (a, 1-11) and 115.331 (b), and 115.331 (c) thereby corroborating their signed acknowledgement statement.

This facility is in compliance with this standard.

Corrective Action Findings: None

Standard 115.332: Volunteer and contractor training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.332 (a)

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

115.332 (b)

- Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)? ☒ Yes ☐ No

115.332 (c)

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. Shamar Hope Haven RTC Zero Tolerance Policy
c. PREA Training Documentation of Volunteer and Contractor

Interviews included:

a. Program Director / PREA Compliance Manager
b. Random Staff
c. Volunteer and Contractor

Site Review / Observations:
a. None

115.332 (a) The SHHRTC Zero Tolerance Policy, (pg. 7) states that "SHHRTC ensures and documents all volunteers and contractors who have direct access to resident have been trained on and understand their responsibilities under PREA and any other SHHRTC policies and procedures". A review of the 1 volunteer file revealed that she has not been trained on her responsibilities under the agency's Zero Tolerance policy. A review of the contractual employees file revealed that he has been trained on his responsibilities under the agency's Zero Tolerance policy. SHHRTC is not compliant with this provision.

115.332 (b) The SHHRTC Program Director/ PREA Coordinator did provide documentation of contractor's acknowledgement of their PREA responsibilities and training necessary for compliance with this provision but did not provide documentation of the volunteer's acknowledgement of their PREA responsibilities and training necessary for compliance. This auditor interviewed the volunteer and ascertained that he only volunteers at the facility quarterly but have received the PREA brochure that informs him of his responsibilities for reporting sexual abuse and sexual harassment.

115.332 (c) A review of the contractors' files revealed that SHHRTC does maintain documentation confirming that the contractor understood the training he received. This auditor only received a copy of the contractor training documentation, who provides assessment and therapeutic services for the facility's residents. The proof documentation that the volunteer was provided with a PREA brochure and understood the agency's Zero Tolerance policy was not provided to this auditor. This facility is not in compliance with this provision.

Corrective Action Findings: SHHRTC must provide proof documentation in the form of an acknowledgement statement that the volunteer, based on his frequency in the facility, has been provided the PREA brochure in order to be in compliance with this standard.

Corrective Action Response: SHHRTC did provide to this auditor proof documentation in the form of an acknowledgement statement that the volunteer, based on his frequency in the facility, was provided the PREA brochure to ensure his understanding of his PREA reporting responsibilities.

This facility is in compliance with this standard.

Standard 115.333: Resident education

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.333 (a)

- During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No
- Is this information presented in an age-appropriate fashion? ☒ Yes ☐ No

115.333 (b)

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No
- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents? ☒ Yes ☐ No

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

115.333 (c)

- Have all residents received the comprehensive education referenced in 115.333(b)? ☒ Yes ☐ No

- Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility? ☒ Yes ☐ No

115.333 (d)

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

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

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

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

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

115.333 (e)

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

115.333 (f)

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. Shamar Hope Haven RTC Zero Tolerance Policy
c. Zero Tolerance Posters
d. Resident Handbook
e. PREA Brochure

Interviews included:

a. Program Director/ PREA Manager
b. Intake Staff
c. Staff who perform risk screening for sexual victimization and abusiveness
d. Random Staff

Site Review / Observations:

a. Posters affixed in areas commonly used by residents such as:
    i. Residential House (Truxillo House)
    ii. Dining and common areas
    iii. Administration Building Hallways
    iv. Intake areas
    v. Supervisor's office
b. PREA brochures available to residents
c. Safeguarding Your Sexual Safety Video

115.333 (a) The SHHRTC Zero Tolerance Policy, (pg. 8) states that "during the admissions/intake process the resident are provided, by SHHRTC, age appropriate PREA information about the agencies Zero Tolerance Policy and how to report incidents or suspicions of sexual abuse, sexual harassment or sexual activity". This is done through verbal explanation by the intake staff after being provided the appropriate PREA education information in the PREA brochure and in the Resident Handbook. The Safeguarding Your Sexual Safety video does address the following points:

- Resident rights to be free from sexual abuse and sexual harassment
- Their rights to be free from retaliation for reporting such incidents
- The agency's policies and procedures for responding to such incidents.

The SHHRTC Program Director/PREA Compliance Manager did provide this auditor with the SHHRTC Resident Handbook in English and Spanish.

During the random resident interviews, 11 of 11 residents reported that this information was provided and explained to them upon intake. They further indicated that they understand the zero-tolerance policy and know how to report a sexual abuse and sexual harassment allegation.

Over the past twelve months 90 residents were admitted to SHHRTC and all of the intake packets included an acknowledgement signed by each resident that they received and understood the zero-tolerance policy information. When reviewing resident files, auditors found no evidence that there were residents who did not receive the required Zero Tolerance Policy information.

115.333 (b) The SHHRTC Zero Tolerance Policy, (pg. 8) states that "within 10 days after admission, SHHRTC provides comprehensive, age appropriate education to resident about their rights to be free from sexual abuse, sexual harassment, and retaliation for reporting". Through the random resident interviews this auditor found evidence that 11 of 11 residents had viewed the Safeguarding Your Sexual Safety PREA Video within 24 hours of their intake. This video is presented in an age-appropriate fashion.

This auditor did receive a copy of the video as proof of the actual PREA education being provided to residents. Upon review of the video, it does inform the youth of:

- Their rights to be free from retaliation for reporting such incidents
- The agency's policies and procedures for responding to such incidents.

115.333 (c) During the random resident interviews 11 of 11 residents interviewed indicated that they had received the comprehensive education either on the day of intake or the following day. A review of the resident files indicated that all 11 residents acknowledged that they did receive the comprehensive education within 10 days from intake. The records further corroborated that they received this comprehensive education within a day after their intake.

During the intake staff interview this auditor asked how they ensured current residents as well as those transferred from other facilities were educated on the agency's Zero Tolerance Policy. She stated that regardless of how, when, or where a resident comes to the facility, they are provided with the same comprehensive education about their rights to be free from sexual abuse, sexual harassment, retaliation and how to report a sexual abuse and sexual harassment allegation.

115.333 (d) The SHHRTC intake staff provided this auditor with the resident education in formats accessible to all residents at the facility during this audit, including materials translated into Spanish.

Auditors were able to review a documented Memorandum of Agreement between SHHRTC and the Harris County Independent School District (HISD) regarding the provision of providing resident education for resident who are:

- Limited in English Proficient
- Visually impaired
- Otherwise disabled
- Having limited reading skills

The Executive Director/PREA Coordinator indicated during her interview that HISD would provide assistance to them in creating education materials in formats accessible for residents that are deaf, visually impaired, have limited reading skills, otherwise disabled or have limited reading skills. When intake staff were asked how residents with limited reading skills could benefit from the PREA related information, she responded that the staff would read the printed information to the resident with the limited reading skills, have the resident watch the video, stop and explain the video and show the resident how they can call the 1 800 hotline number to report a sexual abuse and sexual harassment allegation.

115.333 (e) The SHHRTC Program Director/ PREA Compliance Manager did provide copies of the resident training rosters of the comprehensive education and signed acknowledgement statements from 11 of the 11 residents that they received and understood the PREA information.

115.333 (f) During the site review of the SHHRTC this auditor did observe PREA posters in the residential houses (Truxillo and Wheeler). These posters did include the 1-800 phone number for reporting a sexual abuse and sexual harassment allegation as well as the name and phone number for seeking emotional support and crisis intervention. This auditor also received a copy of and reviewed the PREA information that is in the resident handbook.

PREA brochures and Zero Tolerance flyers were observed during the site review in the lobby of the administration building, in both the common areas, group rooms, and dining areas of the Truxillo and Wheeler house.

This facility is in compliance with this standard.

Corrective Action Findings: None

Standard 115.334: Specialized training: Investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.334 (a)

- In addition to the general training provided to all employees pursuant to §115.331, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)
  ☐ Yes ☐ No ☒ NA

115.334 (b)

- Does this specialized training include techniques for interviewing juvenile sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☐ Yes ☐ No ☒ NA

- Does this specialized training include proper use of Miranda and Garrity warnings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☐ Yes ☐ No ☒ NA

- Does this specialized training include sexual abuse evidence collection in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☐ Yes ☐ No ☒ NA

- Does this specialized training include the criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☐ Yes ☐ No ☒ NA

115.334 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☐ Yes ☐ No ☒ NA

115.334 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. Shamar Hope Haven RTC Zero Tolerance Policy
c. Memorandum of Understanding with the Harris County Sheriff Department

Interviews included:

a. Program Director / PREA Compliance Manager
b. Executive Director/PREA Coordinator
c. Random Staff
d. Staff on the Incident Review Team

Site Review / Observations:

a. None

115.334 (a) SHHRTC Zero Tolerance Policy, (pg. 8) states that “SHHRTC staff member are not qualified to investigate allegations of sexual abuse and sexual harassment”. The Executive Director/PREA Coordinator indicated during her interview that no one in her staff is qualified to conduct sexual abuse and sexual harassment investigations. These allegations are referred to either the Harris County Sheriff Department (HCSD) for criminal investigations or to the Texas Department of Family and Protective Services (TXDFPS) Licensing Division for Administrative investigations. This provision is not applicable to this agency.

115.334 (b) Because administrative and criminal investigations are the responsibility of HCSD and TXDFPS, SHHRTC staff are not required to have specialized training including techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. This provision is not applicable to this agency.

115.334 (c) Because administrative and criminal investigations are the responsibility of HCSD and TXDFPS, SHHRTC staff are not required to provide documented proof that HCSD and TXDFPS personnel have received the required specialized training. This provision is not applicable to this agency.

115.334 (d) Auditor is not required to audit this provision.

This facility is in compliance with this standard.

Corrective Action Findings: None

Standard 115.335: Specialized training: Medical and mental health care

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.335 (a)

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

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

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

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

115.335 (b)

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

115.335 (c)

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

115.335 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

- Do medical and mental health care practitioners contracted by or volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. Shamar Hope Haven RTC Zero Tolerance Policy
c. PREA Training Documentation for Contracting Mental Health staff

Interviews included:

a. Program Director/PREA Compliance Manager
b. Executive Director/ PREA Coordinator

Site Review / Observations:

a. None

115.335 (a) The SHHRTC Zero Tolerance Policy, (pg. 8)) states that SHHRTC ensures and maintains documentation that all full and part-time medical and mental health practitioners who work in SHHRTC operated facilities have been trained in how to:

1. How to detect and assess sins of sexual abuse and sexual harassment.
2. How to preserve physical evidence of sexual abuse.
3. How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment.
4. How and to whom to report allegations of sexual abuse and harassment.

SHHRTC does not have any full or part time medical practitioners employed at the agency. Upon review of the training file of the mental health therapist and the contracting Mental Health staff revealed that they have not received specialized training from the National Institute of Corrections (NIC) training portal for Behavioral Health Practitioners that addresses the following training topics:

- How to detect and assess signs of sexual abuse and sexual harassment
- How to preserve physical evidence of sexual abuse
- How to respond effectively and professionally to juvenile sexual abuse victims of sexual abuse and sexual harassment.
- How and to whom to report allegations or suspicion of sexual abuse and sexual harassment.

They both have received the basic in classroom 8-hour PREA training that the direct care staff received in the last 12 months.

115.335 (b) SHHRTC Human Resource staff indicated that they do not employ any medical staff therefore, no SHHRTC staff is required to receive training related to forensic exams. This provision is not applicable to this agency.

115.335 (c) SHHRTC Human Resource staff did provide to this auditor documentation of the PREA training received by the mental health therapist and the contracting mental health practitioner. No specialized training has been received by the mental health therapist nor the contracting mental health practitioner in the last 12 months. This facility is not in compliance with this provision.

115.335 (d) SHHRTC Human Resource staff indicated that they do not employ any medical staff but she did provide to this auditor documentation of the PREA training received by the mental health therapist and contracting mental health practitioner as mandated by employees by 115.331 and 115.332.

Corrective Action Findings: This facility must ensure that the contracting mental health staff and the mental health therapist receive the specialized training for Behavioral Health Care Practitioners, that is

found on the National Institute of Corrections website (www.nicic.gov,) in order to be in compliance with the standard.

Corrective Action Response: SHHRTC did provide to this auditor proof documentation in the form of certificates that the contracting mental health staff and the mental health therapist did receive the specialized training for Behavioral Health Care Practitioners, that is found on the National Institute of Corrections website (www.nicic.gov,).

This facility is in compliance with this standard.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.341: Screening for risk of victimization and abusiveness

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.341 (a)

- Within 72 hours of the resident's arrival at the facility, does the agency obtain and use information about each resident's personal history and behavior to reduce risk of sexual abuse by or upon a resident? ☒ Yes ☐ No

- Does the agency also obtain this information periodically throughout a resident's confinement? ☒ Yes ☐ No

115.341 (b)

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

115.341 (c)

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (1) Prior sexual victimization or abusiveness? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (3) Current charges and offense history? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (4) Age? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (5) Level of emotional and cognitive development? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (6) Physical size and stature? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (7) Mental illness or mental disabilities? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (8) Intellectual or developmental disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (9) Physical disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (10) The residents' own perception of vulnerability? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents? ☒ Yes ☐ No

115.341 (d)

- Is this information ascertained through conversations with the resident during the intake process and medical mental health screenings? ☒ Yes ☐ No

- Is this information ascertained during classification assessments? ☒ Yes ☐ No

- Is this information ascertained by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files? ☒ Yes ☐ No

115.341 (e)

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. Shamar Hope Haven RTC Zero Tolerance Policy
c. Risk Screening Intake Instrument

Interviews included:

a. Program Director/PREA Manager
b. Executive Director/PREA Coordinator
c. Intake Staff
d. Random Resident

Site Review / Observations:
a. None observed.

115.341 (a) The SHHRTC Zero Tolerance Policy, (pg. 8) states that "SHHRTC does use an objective screening instrument within 72 hours after a resident's admission to SHHRTC to obtain information about the resident's personal history and behavior to reduce the risk of sexual abuse by or upon another resident".

Upon file review of the residents file, this auditor randomly selected 11 resident files and found that 100% of these files had a risk screening completed within the 72-hour time period. Upon further review it was ascertained that SHHRTC does not periodically obtain information throughout a resident's stay in this facility. This facility is not in compliance with this standard.

115.341 (b) SHHRTC Zero Tolerance Policy, (pg. 8) states that "periodically throughout the resident's stay, information from the screening instrument is used to reassess housing and supervision assignments". The Intake staff indicated during her interview that residents are not provided a periodic screening assessment during their stay to assess housing and supervision assignments. The facility is not in compliance with this provision.

115.341 (c) The screening instruments used at SHHRTC, does not attempt to ascertain the following information:

1. Prior sexual victimization or abusiveness;
2. Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore vulnerable to sexual abuse;
3. Current charges and offense history;
4. Age;
5. Level of emotional and cognitive development;
6. Physical size and stature;
7. Mental illness or mental disabilities;
8. Intellectual or developmental disabilities;
9. Physical disabilities;
10. The residents own perception of vulnerability; and
11. Any specific information about individual residents that may indicate heightened need for supervision, additional safety precautions, or separation from certain residents.

During the interview with the Intake staff it was ascertained that some information was not being captured and or asked during the risk screening i.e. number 3, 5, 9, and 10 as required from this provision. The facility is not in compliance with this provision.

115.341 (d) This auditor ascertained through the resident file audit and the Intake staff interview that the risk assessments are being conducted through conversation with the resident during the intake, classification process; from the mental health screenings and from reviewing court records and other relevant documentation. Documentation of the intake screening were provided to this auditor.

115l341 (e) The Executive Director/PREA Coordinator and Intake staff indicated during interviews that the information obtained during the initial, and follow up screening is sensitive and treated as confidential, therefore the information has limited dissemination and access to prevent exploitation. This information is controlled by double locking the paper files in a file cabinet of the secretary's office, electronic files are password protecting the electronic records and only authorized employees are permitted to view the protected information on a need to know basis. During the site review this auditor was able to review these files in the secretary's office, where they were stored.

Recommendation: This auditor recommends that SHHRTC Intake staff create a document to periodically assess a resident every 90 days of their stay (since they are there a minimum of 6 months). Use the artifact provided and discussed during debriefing.

Corrective Action Findings: This facility must update the risk screening instrument to include elements 3, 5, 9, and 10 of this standard as well as begin conducting periodic assessments of the residents during their stay at SHHRTC. Proof documentation must be provided in order to be in compliance with this standard.

Corrective Action Response: SHHRTC did provide to this auditor an updated copy of the risk screening instrument that included elements 3, 5, 9, and 10 of this provision, a re-assessment screening instrument, as well as completed copies of both to demonstrate implementation in conducting periodic assessments of the residents during their stay at SHHRTC.

This facility is in compliance with this standard.

Standard 115.342: Use of screening information

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.342 (a)

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Housing Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Bed assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Work Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Education Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Program Assignments? ☒ Yes ☐ No

115.342 (b)

- Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

- During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

- Do residents in isolation receive daily visits from a medical or mental health care clinician? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

- Do residents in isolation also have access to other programs and work opportunities to the extent possible? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

115.342 (c)

- Does the agency always refrain from placing lesbian, gay, and bisexual (LGB) residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from placing transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from placing intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex (LGBTI) identification or status as an indicator or likelihood of being sexually abusive? ☒ Yes ☐ No

115.342 (d)

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

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

115.342 (e)

- Are placement and programming assignments for each transgender or intersex resident reassessed at least twice each year to review any threats to safety experienced by the resident? ☒ Yes ☐ No

115.342 (f)

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

115.342 (g)

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

115.342 (h)

- If a resident is isolated pursuant to provision (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

- If a resident is isolated pursuant to provision (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

115.342 (l)

- In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. Shamar Hope Haven RTC Zero Tolerance Policy
c. Risk Screening Intake Instrument
d. Resident Files

Interviews included:

a. Program Director / PREA Manager
b. Executive Director/PREA Coordinator
c. Intake Staff
d. Random Residents

Site Review / Observations:

a. Facility Site Review - No isolation Rooms were observed.

115.342 (a) SHHRTC's Zero Tolerance Policy, (pg. 8) states that SHHRTC "uses all information obtained during intake screening to make housing, bed, program, education, and work assignments for resident". The Intake staff as well as the Executive Director/PREA Coordinator confirmed in their interviews that information learned during the intake screening is used to make informed housing assignments. Furthermore, the housing assignments are discussed anytime there is an incident and moving residents to another bedroom, work educational or program assignment with the goal of keeping them safe from sexual abuse and sexual harassment will be considered.

115.342 (b) The SHHRTC Zero Tolerance Policy prohibits the use of isolation, therefore SHHRTC avoids isolating residents due to risk of sexual victimization. During the onsite audit this auditor walked freely throughout the facility and was given access to all areas as requested. This facility never places residents in isolation nor is the facility designed for such according to the Truxillo and Wheeler House schematics.

1for any reason15.342 (c) SHHRTC Executive Director/PREA Coordinator and the Intake staff indicated during their interview that SHHRTC does not place Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) residents in a particular house, bed, or other assignment solely on the basis of such identification. SHHRTC reported on the PAQ of having zero LGBTI resident in the 12 months.

The Program Director/PREA Compliance Manager indicated during her interview that if an LGBTI resident were in the program that SHHRTC would always refrain from considering lesbian, gay, bisexual, transgender, or intersex (LGBTI) identification or status as an indicator or likelihood of being sexually abusive.

115.342 (d) SHHRTC is an all-male facility. The Intake Staff and the PAQ reported no LGBTI residents in the past 12 months. The Intake staff stated in her interview that the housing assignments would be made on a case by case basis and as with all resident the assignment would be based on ensuring the residents health and safety, and whether placement would present management or security problems. SHHRTC reported on the PAQ of having zero transgender and intersex residents in the facility during the last 12 months.

115.342 (e) At the time of this audit and in the last 12 months SHHRTC reported that there were no residents who identified as transgender or intersex at the facility. SHHRTC Zero Tolerance Policy, (pg.8) does state that "transgender and intersex resident housing assignments and programing assignments would be reassessed at least twice each year to review any threats to safety experienced by the resident" SHHRTC reported on the PAQ of having zero transgender and intersex resident in the 12 months.

115.342 (f) SHHRTC Zero Tolerance Policy, (pg. 8) states that SHHRTC "would give serious consideration to the resident's own views concerning their safety when making placement and programming assignments" for a transgender or intersex resident. SHHRTC reported on the PAQ of having zero transgender and intersex residents in the 12 months.

115.342 (g) SHHRTC's Zero Tolerance Policy states that it would (h) (I) "provides the opportunity for all residents to shower separately". During the facility site review its auditors observed the shower areas which are all single user shower rooms behind a locked door for complete resident privacy. SHHRTC reported on the PAQ of having zero transgender and intersex residents in the 12 months.

115.342 (h) SHHRTC never places residents in isolation nor is the facility designed for such according to the Truxillo and Wheeler House schematics.

115.342 (I) This facility never places residents in isolation nor is the facility designed for such according to the Truxillo and Wheeler House schematics.

This facility is in compliance with this standard.

Corrective Action Findings: None

REPORTING

Standard 115.351: Resident reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.351 (a)

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

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

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

115.351 (b)

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

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

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

- Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment? (N/A if the facility *never* houses residents detained solely for civil immigration purposes.) ☐ Yes ☐ No ☒ NA

115.351 (c)

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

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

115.351 (d)

- Does the facility provide residents with access to tools necessary to make a written report? ☒ Yes ☐ No

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)

b. Shamar Hope Haven RTC Zero Tolerance Policy
c. Resident Files
d. Grievance Policy and Form
e. Resident Handbook
f. Memorandum for Resident Reporting

Interviews included:

a. Program Director/PREA Compliance Manager
b. Executive Director/PREA Coordinator
c. Intake Staff
d. Random staff
e. Designated Staff to monitor for Retaliation
f. Random Residents

Site Review / Observations:

a. Facility Site Review – (Truxillo and Wheeler House)

115.351 (a) SHHRTC Zero Tolerance Policy, (pg. 9) states that SHHRTC "provides multiple internal ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff including staff neglect or violation of responsibilities that may have contributed to such incidents". The SHHRTC Zero Tolerance Policy lists the following ways to report:

(I) Submitting a written grievance, verbally or by any means the resident has access to;
(ii) Calling the 24-hour toll free hotline 1 800-252-5400 without being heard by staff or other residents;
(i) Telling any staff member, volunteer, or contract employee who must then call the hotline and inform the Program Director or Executive Director; or
(ii) Calling the toll-free number maintained by the Texas Department of Family Protective Services (TDFPS) which is a separate state agency. Also, without being heard by staff or residents.

During the interviews with the random residents they all indicated their knowledge of reporting a sexual abuse and sexual harassment, retaliation or staff neglect allegations by either telling a staff member, write a grievance or call the agency's anonymous number that is listed in the PREA brochure. This auditor observed in both houses the PREA brochure displaying the agency's anonymous number that a resident can call to report a sexual abuse and sexual harassment allegation or incident. During the random staff interviews they all indicated the ways a resident can report a sexual abuse and sexual harassment allegation by informing them, writing a grievance, calling the 1800 number or the agency's anonymous number that is directly to the Executive Director.

115.351 (b) SHHRTC Zero Tolerance Policy, (pg. 9) states that "a residents may call the toll-free number maintained by the Texas Department of Family Protective Services (TXDFPS), 1 (800) 252-5400, which is a separate state agency to report a sexual abuse, sexual harassment, retaliation or staff neglect allegation. TXDFPS, according to the Executive Director/PREA Coordinator, does receive and immediately forwards these allegation calls to the Executive Director. The TXDFPS hotline operator confirmed this procedure. During the random resident interviews each one indicated that they could make this call in a private area like the supervisor's office, without being heard by the staff or other residents and could remain anonymous upon request.

The Executive Director/PREA Coordinator did provide to this auditor during the pre-audit phase a memorandum stating that within the last 12 months no residents have been housed in this facility solely for immigration purposes. She also indicated such on the PAQ provided.

115.351 (c) SHHRTC Zero Tolerance Policy, (pg. 9) states that staff will "promptly accepts verbal and written reports made anonymously or by third parties and promptly document any verbal reports". During the interview with the random staffs when asked this question, each staff stated that they would accept verbal reports of sexual abuse and sexual harassment verbally, in writing, anonymously, from third parties and would document them immediately on the agency's indicant report form. A copy of the agency's incident report form was provided to this auditor during the pre-audit phase.

115.351 (d) SHHRTC Zero Tolerance Policy, (pg. 9) states that SHHRTC "provides residents access to grievance forms, writing instruments, to privately make a written report". During the interview with the random residents, they all indicated that they have access to paper, pencils and grievance forms if they want to report a sexual abuse and sexual harassment allegation in writing. This auditor was provided with a blank grievance form during the pre-audit phase. While on the site review this auditor observed the availability of grievance forms and pencils for the resident's usage. During the interviews with the random staff, they all indicated that they could report a sexual abuse, sexual harassment, and retaliation allegation against a resident privately by going to a supervisor's office in person, calling them on the phone, calling the 1 800 number or by writing a note.

This facility is in compliance with this standard.

Corrective Action Findings: None

Standard 115.352: Exhaustion of administrative remedies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.352 (a)

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

115.352 (b)

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

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

115.352 (c)

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

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

115.352 (d)

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

- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)], does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (e)

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

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

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

- Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned

upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (f)

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

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

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

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

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

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

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

115.352 (g)

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. Shamar Hope Haven RTC (SHHRTC) Zero Tolerance Policy
c. Resident Handbook
d. Grievance Policy and Form
e. Resident File review
f. Third Party Reporting Form
g. Memorandum on Exhaustion on Administrative Remedies

Interviews included:

a. Executive Director / PREA Coordinator
b. Intake Staff
c. Random Staff
d. Random Residents

Site Review / Observations:

a. Agency website

115.352 (a) This standard does apply to SHHRTC because they do have administrative procedures to address all resident grievances and does have an administrative remedy process to address sexual abuse.

115.352 (b) SHHRTC Zero Tolerance Policy states that (2) (A), SHHRTC "investigates all allegations of sexual abuse regardless of how much time has passed since the alleged incident". Furthermore, the Zero Tolerance policy states that "residents are not required to use the grievance system or the informal conference request system to report an allegation of sexual abuse and are not required to attempt to resolve the allegation with staff". During the interviews with the Executive Director/PREA Coordinator and the Program Director/PREA Compliance Manager corroborated this policy statement as a practice of refraining from requiring a resident to use any informal grievance process in an attempt to resolve with a sexual abuse or sexual harassment allegation with staff member. The Intake staff stated during her interview that all residents during Intake are verbally informed of this procedure. During several of the resident interviews they stated that if they had a grievance that they would seek resolution first with that staff member, then the supervisor then the Executive Director. A review of the resident's handbook does not reflect the procedure of instructing the resident that they are not required to use the grievance system to report an allegation of sexual abuse or the informal conference request system to resolve the allegation with staff. The facility is not in compliance with this provision.

115.352 (c) SHHRTC Zero Tolerance Policy, (pg. 9) states that " a resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint and that such grievances are not referred to a staff member who is the subject of a complaint". During the interviews with the Executive Director/PREA Coordinator and the Program Director/PREA Compliance Manager corroborated this policy statement as a practice of refraining from requiring a resident to use any informal grievance process in an attempt to resolve with a sexual abuse or sexual harassment allegation with staff member. The Intake staff stated during her interview that all residents during Intake are verbally informed of this procedure. A review of the resident's handbook does not reflect the procedure of instructing the resident that they are not required to submit the complaint to a staff member who is the subject of a complaint". The facility is not in compliance with this provision.

115.352 (d) The Executive Director/PREA Coordinator indicated during her interview that the agency does issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance. She also acknowledged that if they determined that the 90-day timeframe is insufficient that she would make an appropriate decision, claim an extension of time of not more than 70 days, and notify the resident in writing of any such extension and provide a date by which a decision will be made. She further stated that if the resident does not receive a response, they could consider the absence of a response to be a denial at that level and can then pursue outside ligation. During the interviews of the random residents, random staff, and a review of the grievances of the past 12 months, this auditor found zero grievances for sexual abuse or sexual harassment.

115.352 (e) SHHRTC Zero Tolerance Policy, (pg. 9) states that SHHRTC "accepts verbal and written reports made anonymously or by third parties and promptly documents verbal reports". SHHRTC publicly distributes information on the agency's website for third party report.

According to SHHRTC's Zero Tolerance Policy, third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse. Third party forms were observed and available to the public on the agency's website as well as were provided to this auditor during the pre-audit phase. The Program Director/PREA Compliance Manager indicated during her interview that third parties are permitted to file such requests on behalf of residents, if a resident were to decline to have a third-party request processed on his behalf, that SHHRTC would document the resident's decision. She further stated that SHHRTC accepts third party allegations and grievances from anyone, this includes appeals on behalf of the resident, from a parent or legal guardian and that no grievance would be conditioned upon the resident agreeing to have a request filed on his behalf.

115.352 (f) SHHRTC has an open-door policy to the Executive Director/PREA Coordinator, Program Director/PREA Compliance Manager and the Supervisor's offices that a resident can file an emergency grievance alleging that they are subject to a substantial risk of imminent sexual abuse. During the interviews with the random staff, they all responded that if a resident submitted an emergency grievance or approached them indicating that they are at risk of imminent sexual abuse that they would take immediate action to keep the youth safe and immediately contact their supervisor.

It was observed during the site review and throughout the onsite audit that SHHRTC's administrators do maintain constant communication with their direct care staff and residents. That any grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, would be immediately reviewed at the highest level of the agency and then would be forwarded to TXDFPS Licensing Division and to the Harris County Sheriff Department for investigating. All staff interviewed mentioned separating a resident from a situation that had imminent risk of sexual abuse.

The Executive Director/PREA Coordinator indicated that after receiving an emergency grievance, that she or the Program Director/PREA Compliance Manager would provide an initial response to the resident within 48 hours. Because SHHRTC does not conduct any investigations and any grievance related to sexual abuse and sexual harassment would be forwarded to TXDFPS Licensing Division and the Harris County Sheriff Department since they are exempt from this provision of issuing a final decision within 5 calendar days. The Program Director/PREA Compliance Manager stated that they will provide to the resident, after the initial response to their emergency grievance, a final decision as to whether the resident is in substantial risk of imminent sexual abuse.

115.352 (g) SHHRTC's Zero Tolerance Policy, (pg. 9) states that the agency "may discipline a resident for filing a grievance related to alleged sexual abuse if the resident filed the grievance in bad faith". The

SHHRTC Executive Director PREA Coordinator indicated during her interview that no resident had been disciplined for filing any grievance in bad faith. A review of the grievances filed over the past 12 months revealed that there were zero grievances alleging sexual abuse or sexual harassment. During the interviews the random residents they all reported feeling safe at SHHRTC and that they could file a sexual abuse or sexual harassment allegation without fear of retaliation.

Corrective Action Findings: SHHRTC must update the resident handbook to include the following statement" "residents are not required to use the grievance system or the informal conference request system to report an allegation of sexual abuse or sexual harassment and are not required to attempt to resolve the allegation with the staff member who is the subject of the complaint", in order to be in compliance with this standard..

Corrective Action Response: SHHRTC did provide to this auditor a copy of the updated resident handbook that does include the following statement" "residents are not required to use the grievance system or the informal conference request system to report an allegation of sexual abuse or sexual harassment and are not required to attempt to resolve the allegation with the staff member who is the subject of the complaint".

This facility is in compliance with this standard.

Standard 115.353: Resident access to outside confidential support services and legal representation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.353 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making assessible mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? ☒ Yes ☐ No

- Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies? (N/A if the facility *never* has persons detained solely for civil immigration purposes.) ☐ Yes ☐ No ☒ NA

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

115.353 (b)

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

115.353 (c)

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

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

115.353 (d)

- Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation? ☒ Yes ☐ No

- Does the facility provide residents with reasonable access to parents or legal guardians? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. Shamar Hope Haven RTC (SHHRTC) Zero Tolerance Policy
c. Memorandum of Understanding with SARC
d. Zero Tolerance PREA Posters
e. Facility Schematics of Truxillo and Wheeler House's visitation space
f. Resident Handbook

Interviews included:

a. Executive Director / PREA Coordinator
b. Intake Staff
c. Random Staff
d. Random Residents

Site Review / Observations:

a. Telephone locations and resident's ability to make confidential calls.
b. Rooms provided for confidential resident meetings with lawyers, advocates, and parents.

115.353 (a) The SHHRTC Zero Tolerance Policy, (pg. 10) states how all residents have "access to outside confidential support services related to sexual abuse and harassment. SHHRTC also provides residents with access to representatives of such local, State, or national victim advocacy or rape crisis organizations". SHHRTC does not detained residents solely for civil immigration purposes, therefore no postings or brochures include contact information for immigration services is required.

During the interview with the random resident, 11 of 11 residents confirmed they believed a call to outside support services would be private and confidential. During the interview with the random staff, 12 of 12 staff interviewed confirmed that residents would be provided a private space to make a confidential phone call any of these agencies upon request.

This auditor observed during the site review in the houses the following phone numbers posted on the bulletin board:

- Sexual Assault Recovery Center 24-hour Crisis Hotline (SARC) (713-528-7273)
- The Texas Department of Family and Protective Services (TXDFPS) (1- 800- 252-5400)

During the interview with the Intake staff she indicated that residents are also provided with information about SARC. The SARC representative reported that there were no calls on record from SHHRTC in the past 12 months requesting their services.

115. 353 (b) The Intake staff indicated during her interview that the residents are informed during intake the extent to which communications with these agencies will be monitored and the extent to which reports of sexual abuse being reported to them will be forwarded to the authorities in accordance to mandatory reporting laws. During the interviews with the random staff they all reported that they are mandated to report of sexual abuse and sexual harassment by state law. The intake staff and Program Director/PREA Compliance Manager interviewed acknowledged that the residents are informed of the mandatory reporting rules governing privacy, confidentiality, and/or privileges that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant Federal, State, or local law. The Intake staff indicated that verbal notification would be provided to the resident before discussing sexual abuse and sexual harassment allegation with the residents. SHHRTC random staff and management confirmed in during their respective interviews that the resident's phone calls are not monitored or recorded.

115.353 (c) SHHRTC did provide a copy of the Memorandum of Understanding with the Sexual Assault Resource Center (SARC) during the pre-audit phase that provide residents with confidential, emotional support and victim services related to sexual abuse and sexual harassment. The SARC provide emotional support services to members of the public, including residents of SHHRTC, free of charge and can also be provided in-person or by phone.

115.353 (d) SHHRTC's Zero Tolerance Policy (3) (A-C) states that SHHRTC "does provide residents with reasonable and confidential access to their attorneys or legal representation, parents, and legal guardians". During the site review this auditor observed the group rooms in each house (Truxillo and Wheeler) that is used for parental and legal visits. Parents, guardians and attorneys have reasonable access to the residents by contacting the facility to schedule a visit. During the random resident interviews each one explained that they could meet with their legal representatives, parents, and legal guardians in a confidential manner in the facility if required or requested by either party.

This facility is in compliance with this standard.

Corrective Action Findings: None

Standard 115.354: Third-party reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.354 (a)

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

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. Shamar Hope Haven RTC Zero Tolerance Policy
c. Zero Tolerance PREA Posters
d. 3rd Party Reporting Form

Interviews included:

a. Executive Director/PREA Coordinator
b. Program Director/PREA Compliance Manager
c. Random Residents
d. Random Staff

Site Review / Observations:

a. Zero Tolerance Postings
b. Availability of Third-Party Reporting forms.
c. Agency Web Site

115.354 The SHHRTC Zero Tolerance Policy, (pg. 10) does describes the procedures to receive and for making a 3rd party report of sexual abuse and harassment on behalf of a resident. This auditor did observe the link regarding 3rd party reporting procedure on the agency website but the link did not work. The Executive Director/PREA Coordinator did provide a copy of the 3rd party reporting form during the pre-audit phase. She reported that there have been no 3rd party grievances of sexual abuse and harassment on behalf of a resident in the last 12 months. SHHRTC is not in compliance with this standard.

Corrective Action Findings: SHHRTC must update their website's link to the 3rd party reporting form to include access or to provide directions for third party individuals on how to file a complaint or allegation of sexual abuse or sexual harassment on behalf of a resident in order to be in compliance with this standard.

Corrective Action Response: SHHRTC did provide to this auditor the link to the agency's website in order to review the 3rd party reporting form, which included directions for third party individuals on how to file a complaint or allegation of sexual abuse or sexual harassment on behalf of a resident.

This facility is in compliance with this standard.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.361: Staff and agency reporting duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.361 (a)

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? ☒ Yes ☐ No

115.361 (b)

- Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws? ☒ Yes ☐ No

115.361 (c)

- Apart from reporting to designated supervisors or officials and designated State or local services agencies, are staff prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions? ☒ Yes ☐ No

115.361 (d)

- Are medical and mental health practitioners required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws? ☒ Yes ☐ No

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

115.361 (e)

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office? ☒ Yes ☐ No

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified? ☒ Yes ☐ No

- If an alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? ☒ Yes ☐ No

- If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation? ☒ Yes ☐ No

115.361 (f)

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. Shamar Hope Haven RTC Zero Tolerance Policy
c. Zero Tolerance PREA Posters
d. 3rd Party Reporting Form

Interviews included:

a. Program Director/PREA Coordinator
b. Executive Director/PREA Coordinator
c. Random Residents
d. Random Staff
e. Intake Staff

Site Review / Observations:

a. Zero Tolerance PREA Postings in both houses

115.361 (a) SHHRTC's Zero Tolerance Policy, (pg. 10) does state that all staff "must immediately report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment, retaliation against residents or staff who reported an incident any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation whether or not it is part of the agency". During the interviews with the random staff they all indicated that they had a duty to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment, retaliation against residents or staff who reported an incident any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation.

115.361 (b) SHHRTC Zero Tolerance Policy, (pg. 10) states that "all staff must comply with any applicable mandatory child abuse reporting laws in Texas Family Code Chapter 261 and other applicable professional licensure requirements". During the interviews with the random and specialized staff they all indicated that they are mandated by law to report sexual abuse allegations against a resident to the agency, the contracting and licensing agencies and to local law enforcement.

115.361 (c) SHHRTC Zero Tolerance Policy, (pg. 10) states that "staff are prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions". During the interviews with the random staff they all indicated that they would not inform other staff of an incident of sexual abuse or sexual harassment against a resident other than the extent necessary to make treatment, investigation and other security and management decisions.

115.361 (d) SHHRTC does not have any medical staff, but one of the mental health practitioners reported that she is required to report sexual abuse to her designated supervisors, the Executive Director, pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws. She further stated that she is required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services. During the with the Program Director/PREA Compliance Manager who is also a mental health therapist, she stated that each resident is informed of the limitations on confidentiality and her duty to report a sexual abuse.

115.361 (e) Upon receiving any allegation of sexual abuse, the Executive Director/ PREA Coordinator and the Program Director/PREA Compliance Manager stated during their interviews that they would promptly report an allegation of sexual abuse to the Texas Department of Family Protective Services (TXDFPS) Licensing Division, to the Harris County Sheriff Department, the parent, guardian of the resident, if on probation, the juvenile court of jurisdiction including the probation officer and the resident's attorney of record.

115.361 (f) SHHRTC does not have facility designated investigators so all allegations of sexual abuse and sexual harassment, including 3rd party reports, are immediately reported to TXDFPS and the Harris County Sheriff Department which are the designated investigation agencies.

This facility is in compliance with this standard

Corrective Acton Required: None

Standard 115.362: Agency protection duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.362 (a)

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. Shamar Hope Haven RTC Zero Tolerance Policy
c. Memorandum for Agency Protection Duties

Interviews included:

a. Executive Director/PREA Coordinator
b. Program Director/PREA Compliance Manager
c. Random Residents
d. Random Staff
e. Intake Staff

Site Review / Observations:

a. Agency's website

115.362 (a) SHHRTC Zero Tolerance Policy, (pg. 11) states that "upon receipt a resident is subject to a substantial risk if imminent sexual abuse, SHHRTC staff shall take immediate action to protect the youth". During the interviews of the random staff and specialized staff they all described their responsibility and understanding that when they learn that a resident is subject to a substantial risk of

imminent sexual abuse, that they must take immediate action to protect the resident. Because the facility does not utilize isolation, keeping the resident safe, separating the alleged victim from the alleged perpetrator, housing reassignment, providing one on one supervision, and removing the other person who is causing the imminent risk of sexual abuse or sexual harassment is their procedure according to the Executive Director/PREA Coordinator.

This facility is in compliance with this standard.

Corrective Action: None

Standard 115.363: Reporting to other confinement facilities

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.363 (a)

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

- Does the head of the facility that received the allegation also notify the appropriate investigative agency? ☒ Yes ☐ No

115.363 (b)

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

115.363 (c)

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

115.363 (d)

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. Shamar Hope Haven RTC Zero Tolerance Policy
c. Memorandum on Reporting to other Confinement Facilities

Interviews included:

a. Executive Director/PREA Coordinator
b. Program Director/PREA Compliance Manager
c. Intake Staff

Site Review / Observations:

a. None

115.363 (a) The SHHRTC Zero Tolerance Policy, (pg. 11) does state that SHHRTC must immediately notify the agency head of the facility or appropriate office of the agency where the abuse occurred and that the head of the facility that receives the allegation would also notify the appropriate investigative agency." The Executive Director/PREA Coordinator stated during her interview that she had not received an allegation from a resident during intake alleging that they were sexually abused at another facility in the last 12 months. She further stated that if she would have received one that upon receiving an allegation would notify TXDFPS immediately and then the head of the facility or appropriate office of the agency where the alleged abuse occurred.

115.363 (b) The Executive Director/PREA Coordinator stated during her interview that she would make notification to the head of the facility where the abuse allegedly occurred within 72-hours after receiving the allegation. The Executive Director/PREA Coordinator stated during her interview that she had not received an allegation from a resident during intake alleging that they were sexually abused at another facility in the last 12 months.

115.363 (c) The Executive Director/PREA Coordinator stated during her interview that she would document the notification of sexual abuse related to another facility and maintain a record of it. The Executive Director/PREA Coordinator stated during her interview that she had not received an allegation from a resident during intake alleging that they were sexually abused at another facility in the last 12 months

115.363 (d) The Executive Director/PREA Coordinator indicated during her interview that although there has not been an allegation made in the last 12 months, that she, during the notification process to the facility's head, would ask the facility head to ensure that it be investigated according to this standard.

This facility is in compliance with this standard.

Corrective Action Required: None

Standard 115.364: Staff first responder duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.364 (a)

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

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

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

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

115.364 (b)

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. Shamar Hope Haven RTC Zero Tolerance Policy
c. Employee Training Records

Interviews included:

b. Executive Director/PREA Coordinator

c. Program Director/PREA Compliance Manager
d. Random Staff
e. First Responder Staff

Site Review / Observations:
a. None

115.364 (a) SHHRTC Zero Tolerance Policy, (pg. 11) states that " upon learning a resident was sexually abused, the first staff member to respond to the report is required to separate the alleged victim and abuser, preserve and protect any crime scene until appropriate steps can be taken to collect any evidence and request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence". During the interviews with the all of the random staff and first responders, they all indicated that they would separate the alleged victim and alleged abuser, preserve, protect the crime scene and evidence, and instruct the alleged victim and abuser not to take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. A review of the Employee PREA Training curriculum and "PREA: Your Role Responding to Sexual Abuse" from the NIC training portal corroborates the staff's knowledge, interview response and duty.

115.364 (b) The Executive Director/PREA Coordinator stated during her interview that all SHHRTC staff, including non-security staff, are trained as first responders and have the responsibility to separate the alleged victim from imminent risk, request that the alleged victim not take any actions that could destroy physical evidence as stated above, and then report the incident per policy to the Program Director/PREA Compliance Manager of to herself.

The facility is in compliance with this standard.

Corrective Action Required: None

Standard 115.365: Coordinated response

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.365 (a)

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. Shamar Hope Haven RTC Zero Tolerance Policy
c. Employee Training records

Interviews included:

a. Executive Director/PREA Coordinator
b. Program Director/PREA Compliance Manager
c. Random Staff
d. First Responder Staff

Site Review / Observations:
b. None

115.365 (a) The SHHRTC Zero Tolerance Policy, (pg. 11) does state that they "will maintain a written plan to coordinate the actions taken among first responders, mental health staff, administrators, and leadership". The Executive Director/PREA Coordinator stated during her interview that she has developed and implemented the facility's coordinated response plan in writing. The Program Director/PREA Compliance Manager corroborated this policy requirement during her interview. During the pre-audit phase she also provided this auditor a copy of their written coordination plan. During the interviews with the random and first responder staff they all described the responsibilities direct care and management staff in the event of a sexual abuse or sexual harassment allegation e.g. contact a supervisor, contact law enforcement who would transport the sexual abuse victim to the hospital, etc. in accordance to the written plan.

The facility is in compliance with this standard.

Corrective Action Required: None

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.366 (a)

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

115.366 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. Shamar Hope Haven RTC Zero Tolerance Policy
c. Employee Records

Interviews included:

a. Executive Director/PREA Coordinator
b. Program Director/PREA Compliance Manager
c. Random Staff
d. Random Resident

Site Review / Observations:
a. None

115.366 (a) SHHRTC Zero Tolerance Policy, (pg. 11) states that SHHRTC "shall not enter into any agreement that limits its ability to remove alleged staff sexual abusers from contact with a resident pending the outcome of an investigation or determination of whether and to what extent discipline is warranted". The Executive Director/PREA Coordinator indicated during her interview that SHHRTC does not employ unionized employees therefore they do not participate in collective bargaining and that she can remove an alleged sexual abusers from having contact with residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted.

Upon review of the employee's files there was no indication that if discipline was warranted, including removing an alleged sexual abuse staff member from contact with a resident, that SHHRTC was prevented from doing so due to a collective bargaining agreement. A review of the contractual agreements with Harris, Bexar, Dallas counties including TXDFPS do not prevent SHHRTC from removing an alleged staff sexual abuser from contact with a resident pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted.

115.366 (b) The auditor is not required to audit this provision.

This facility is in compliance with this standard.

Corrective Action Required: None

Standard 115.367: Agency protection against retaliation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.367 (a)

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

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

115.367 (b)

- Does the agency employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services, for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations? ☒ Yes ☐ No

115.367 (c)

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

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

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

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

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

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

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

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

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

115.367 (d)

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

115.367 (e)

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

115.367 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. SHHRTC Zero Tolerance Policy
b. PREA Audit Questionnaire (PAQ)
c. Employee Files
d. Memorandum on Agency Protection against Retaliation

Interviews included:

a. Executive Director/PREA Coordinator
b. Staff Responsible for Monitoring Retaliation
c. Program Director/PREA Compliance Manager
d. Random Staff
e. Random Resident

Site Review / Observations:

a. None

115.367(a) SHHRTC Zero Tolerance Policy, (pg. 11) states that "retaliation by a resident against a residents and staff member who report sexual abuse or sexual harassment or cooperate with an investigation is strictly prohibited". The Executive Director/PREA Coordinator stated during her interview that the Program Director/PREA Compliance Manager and the Staff Designated to monitor for Retaliation is the staff designated to monitoring retaliation against staff or residents that report sexual abuse or harassment.

115.367(b) SHHRTC Zero Tolerance Policy, (pg. 11) states that states they "will use multiple protection measures to protect the resident and staff from retaliation, such as housing transfers, removal of the alleged abuser from contact with the alleged victim, and emotional support services, for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations". During the interview with the staffs designated to monitor for retaliation they both indicated that they would protect the victim by reassigning the alleged abuser to another house, move a staff abuser or place them on administrative leave and would provide emotional support services to the alleged staff or resident abuser.

115.367(c) SHHRTC Zero Tolerance Policy, (pg. 11) states that " for at least 90 days (except when the allegation is unfounded), the designated staff members would monitor the reporter and the alleged victim for signs of retaliation including items such as conduct and treatment of the resident or staff who reported the sexual abuse to see if there are any changes to suggest possible retaliation by residents or staff disciplinary reports, housing or program changes, staff reassignments, negative performance reviews and conducts periodic status checks on the alleged victim". During the interview with the Program Director/PREA Compliance Manager and the designated to monitor for retaliation, they both indicated that they would also monitor in all of the areas as stated above to protect the staff or resident who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with an investigation. They further stated that for at least 90 days following a report of sexual abuse that they would monitor the resident program changes, the reassignment of staff and would continue the monitoring beyond 90 days if the initial monitoring indicates a continuing need. SHHRTC did not report any monitoring of residents or staff for retaliation in the last 12 months.

115.367(d) SHHRTC Zero Tolerance Policy, (pg. 11) states that they would "conduct periodic status checks on the alleged victim". During the interview with the Program Director/PREA Compliance Manager and the designated staff to monitor for retaliation, they both indicated they would conduct period status checks on the alleged victim daily. SHHRTC did not report any monitoring of residents or staff for retaliation in the last 12 months.

115.367 (e) SHHRTC Zero Tolerance Policy, (pg. 11) states that "if any other individual cooperates with an investigation expresses fear of retaliation, they would take appropriate measures to protect that individual against retaliation". During the interview with the Program Director/PREA Compliance Manager and the designated staff to monitor for retaliation, they both indicated that if any other individual who cooperated with an investigation expresses fear of retaliation, that they would take appropriate measures to protect them also against retaliation. SHHRTC did not report any monitoring of residents or staff for retaliation in the last 12 months.

115.367(f) Auditor is not required to audit this provision.

This facility is in compliance with this standard.

Corrective Action Required: None

Standard 115.368: Post-allegation protective custody

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.368 (a)

- Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. SHHRTC Zero Tolerance Policy
b. PREA Audit Questionnaire (PAQ)
c. Facility Schematics of Truxillo and Wheeler House
d. PREA Incident Reports
e. Resident Files
f. Memorandum for Post allegation Protective Custody

Interviews included:

a. Executive Director/ PREA Coordinator
b. Program Director/PREA Compliance Manager
c. Random Staff
d. Random Residents

Site Review / Observations:

a. Site review of Truxillo and Wheeler houses

115.368(a) SHHRTC Zero Tolerance Policy, (pg. 12) states that "SHHRTC does not use of segregated housing to protect a resident who is alleged to have suffered sexual abuse". The Program Director/PREA Compliance Manager and the designated staff assigned to monitor against retaliation both stated during their interviews that SHHRTC does not use segregated housing and if the need ever arises for protecting a resident alleged to have suffered sexual abuse, that they would place the resident in another house, ensure their safety and monitor them daily. During the site review and a review of the facility's schematics, this auditor did not observe any areas in the Truxillo or Wheeler houses that were designated or could be used to segregate a resident alleged to have suffered sexual abuse for their protection. There was no indicated of such during the review of the resident's files.

This facility is in compliance with this standard.

Corrective Action Required: None

INVESTIGATIONS

Standard 115.371: Criminal and administrative agency investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.371 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] ☐ Yes ☐ No ☒ NA

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] ☐ Yes ☐ No ☒ NA

115.371 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334? ☒ Yes ☐ No

115.371 (c)

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

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

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

115.371 (d)

- Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation? ☒ Yes ☐ No

115.371 (e)

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

115.371 (f)

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

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

115.371 (g)

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

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

115.371 (h)

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

115.371 (i)

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

115.371 (j)

- Does the agency retain all written reports referenced in 115.371(g) and (h) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention? ☒ Yes ☐ No

115.371 (k)

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

115.371 (l)

- Auditor is not required to audit this provision.

115.371 (m)

- When an outside agency investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. SHHRTC Zero Tolerance Policy
c. Memorandum of Agreement with Harris County Sheriff Department
d. E-mail from TXDFPS Licensing Division regarding administrative investigation for alleged sexual abuse
e. Resident Files

Interviews included:

a. Executive Director/PREA Coordinator
b. Program Director/ PREA Compliance Manager
c. Supervisory staff
d. Random Staff

Site Review / Observations:

a. None

115.371 (a) SHHRTC Zero Tolerance Policy, (pg. 12) states that “SHHRTC does not conduct its own criminal or administrative investigations”. Criminal investigations are conducted by the Harris County Sheriff Department and administrative investigations are conduct by the Texas Department of Family and Protective Services (TXDFPS) Licensing Division. The Executive Director/PREA Coordinator did provide to this auditor during the pre-audit phase a copy of their contract with TXDFPS and a copy of the Memorandum of Agreement with the Harris County Sheriff Department inclusive of their responsibilities for conducting investigations.

115.371 (b) SHHRTC Zero Tolerance Policy, (pg. 12) states that “SHHRTC does not conduct its own criminal or administrative investigations. Criminal investigations are conducted by the Harris County

Sheriff Department and administrative investigations are conduct by the Texas Department of Family and Protective Services (TXDFPS) Licensing Division. The Executive Director/PREA Coordinator indicated during her interview that TXDFPS and the Harris County Sheriff Department personnel, to her understanding, have received training in conducting in conducting sexual abuse investigations involving juvenile victims.

115.371 (c) SHHRTC Zero Tolerance Policy, (pg. 12) states that they do not conduct its own criminal or administrative investigations. Criminal investigations are conducted by the Harris County Sheriff Department and administrative investigations are conduct by the Texas Department of Family and Protective Services (TXDFPS) Licensing Division. The Executive Director/PREA Coordinator indicated during her interview that she believe that both the TXDFPS and Harris County Sheriff Department's investigators would gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data, interview all alleged victims, suspected perpetrators and witnesses and would review all prior reports and complaints of sexual abuse involving the suspected perpetrator.

115.371 (d) The Executive Director/PREA Coordinator and the Program Director/PREA Compliance Manager stated during their interviews that to their knowledge TXDFPS and the Harris County Sheriff Department would refrain from terminating an investigation solely because the source of the allegation recants the allegation.

115.371 (e) The Executive Director/PREA Coordinator and the Program Director/PREA Compliance Manager stated during their interviews that to their knowledge the Harris County Sheriff Department would conduct interviews of all alleged victims, suspected perpetrators and witnesses as an agency practice and refer those cases where the evidence appears to support criminal prosecution to the local and or state prosecutor. SHHRTC does not conduct any type of investigation and because of this they do not conduct compelled interviews.

115.371 (f) SHHRTC does not conduct any type of investigation and because of this they do not conduct compelled interviews. The Executive Director/PREA Coordinator stated during her interview that she believes that the Harris County Sheriff Department would assess the credibility of an alleged victim, suspect, witness on an individual basis and not on the basis of the individual's status as a resident or staff and that the resident would not be required to submit to a polygraph examination or other truth telling device as a condition for proceeding.

115.371 (g) SHHRTC does not conduct any type of investigation. The Executive Director/PREA Coordinator stated during her interview that she believes that the Texas department of Family Services Licensing Division (TXDFPS), who conducts administrative investigations, to her knowledge, would include an effort to determine whether staff actions or failures to act contributed to the abuse. All administrative investigations are documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind the credibility assessment and the investigative facts and findings. SHHRTC report one allegation for sexual abuse in the last 12 months that was investigated by TDFPS and the findings of that investigation was Unfounded. This auditor did review upon receipt of a copy of this investigative report during the pre-audit phase. The written report did contain a thorough description of the physical, testimonial, and all documentary evidence where feasible.

115.371 (h) SHHRTC does not conduct any type of investigation and in the last 12 months there were no criminal investigations conducted by the Harris County Sheriff Department. The Executive Director/PREA Coordinator stated during her interview that she believes that all criminal investigations

would be documented in written reports that include a description thorough description of the physical evidence and testimonial evidence, the reasoning behind the credibility assessment and the investigative facts and findings.

115.371 (l) The Executive Director/PREA Coordinator stated during her interview that she believes that the Harris County Sheriff Department, who conducts all criminal investigations, would refer them for prosecution. SHHRTC does not conduct any type of investigation and in the last 12 months there were no criminal investigations conducted by the Harris County Sheriff Department.

115.371 (j) SHHRTC Zero Tolerance Policy, (pg. 12) states that they "maintains all written criminal and administrative reports for as long as the alleged abuser is in their program or employed by them, plus at least 5 years". The Executive Director/PREA Coordinator stated during her interview SHHRTC will maintain all written criminal and administrative reports in accordance to this provision of at least 5 years.

115.371 (k) SHHRTC Zero Tolerance Policy, pg. 12) states that they would encourage the TXDFPS or the Harris County Sheriff Department not to terminate an investigation solely on the basis that the alleged abuser or victim is no longer in their program or employed. This auditor found no evidence of TXDFPS and or the Harris County Sheriff Department doing such during the staff and resident file review while onsite.

115.371 (l) Auditor is not required to audit this provision.

115.371 (m) SHHRTC Zero Tolerance Policy, (pg. 13) states that "would cooperate with the TXDFPS and the Harris County Sheriff Department investigators and will attempt to remain informed about the progress of the investigation". The Executive Director/PREA Coordinator and Program Director both indicated during their interviews that they would fully cooperate with TXDFPS and the Harris County Sheriff Department regarding any investigation being conducted for sexual abuse and harassment and would remain involved until the investigation was completed.

The facility is in compliance with this standard.

Corrective Action Required: None

Standard 115.372: Evidentiary standard for administrative investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.372 (a)

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. SHHRTC Zero Tolerance Policy
c. Email from Texas Department of Family and Protective Services Licensing Division
d. Resident Files

Interviews included:

a. Executive Director/ PREA Coordinator
b. Program Director/PREA Compliance Manager
c. Random Staff

Site Review / Observations:

a. None

115.372 (a) SHHRTC Zero Tolerance Policy, (pg. 13) states that "in administrative investigations into allegation of sexual abuse or sexual harassment, the investigator's findings must be based on a preponderance of evidence". The Executive Director/PREA Coordinator did indicate during her interview that the one administrative investigation conducted by TXDFPS in the last 12 months findings were based on the preponderance of evidence.

The facility is in compliance with this standard

Corrective Action Required: None

Standard 115.373: Reporting to residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.373 (a)

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

115.373 (b)

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

115.373 (c)

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

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

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

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

115.373 (d)

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

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

115.373 (e)

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

115.373 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. SHHRTC Zero Tolerance Policy
c. Resident Files
d. Employee Files

Interviews included:

a. Executive Director/PREA Coordinator
b. Program Director/PREA Compliance Manager
c. Random Staff
d. Random Residents

Site Review / Observations:

a. N/A

115.373 (a) SHHRTC's Zero Tolerance Policy, (pg. 13) states that "until a resident is discharged from the facility, SHHRTC will document all notifications and attempted notifications following an investigation into a resident's allegation of sexual abuse suffered in this facility. This would include whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded".

The Executive Director/PREA Coordinator indicated during her interview that the resident who alleged sexual abuse which resulted in an administrative investigation being conducted, was notified of that investigation findings which was Unfounded. A review of the residents file revealed that he was notified of the findings.

115.373 (b) SHHRTC Zero Tolerance Policy, (pg. 13) states that "following a resident's allegation that a staff member will request the information from the investigating agency so the resident may be informed." The Executive Director/PREA Coordinator stated during her interview that they would always request information from the TXDFPS and or the Harris County Sheriff Department to inform the resident of the investigation's outcome. A copy of the TXDFPS investigative report substantiated her assertion.

115.373 (c) SHHRTC Zero Tolerance Policy, (pg. 13) states that "that following a resident's allegation that a staff member committed sexual abuse against the resident, SHHRTC informs the resident whenever the following events occur, except when the allegation is determined to be unfounded, or unless the resident has been released from the program, that they will inform the resident whenever:

- The staff member is no longer posted within the residents housing unit
- The staff member is no longer employed at the facility
- SHHRTC learns that the staff member has been indicted on a charge related to sexual abuse

- Or SHHRTC learns that the staff member has been convicted on a charge related to the sexual abuse

The Executive Director/PREA Coordinator stated during her interview that there have been no staff on resident sexual abuse allegations in the last 12 months.

115.373 (d) SHHRTC Zero Tolerance Policy, (pg. 13) states that "following a resident's allegation that he has been sexually abused by another resident, SHHRTC informs the alleged victim whenever the following events occur:

- SHHRTC learns that the alleged abuser has been indicted on a charge related to the sexual abuse; or
- SHHRTC learns that the alleged abuser has been convicted on a charge related to the sexual abuse.

The Executive Director/PREA Coordinator stated during her interview that there has been no resident on resident sexual abuse allegations in the last 12 months that resulted in a resident abuser being indicted or convicted on a charge of sexual abuse.

115.373 (e) The Executive Director/PREA Coordinator stated during her interview that she has and would continue to document and or attempt all notifications to residents regarding the outcome of an administrative or criminal sexual abuse investigation.

The facility is in compliance with this standard.

Corrective Action Required: None

DISCIPLINE

Standard 115.376: Disciplinary sanctions for staff

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.376 (a)

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

115.376 (b)

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

115.376 (c)

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

115.376 (d)

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

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. SHHRTC Zero Tolerance Policy
c. Resident Files
d. Employee Files
e. Memorandum on Disciplinary Sanctions for Staff

Interviews included:

a. Program Director/PREA Compliance Manager
b. Executive Director/PREA Coordinator
c. Human Resources
d. Random Staff

Site Review / Observations:
a. None

115.376 (a) SHHRTC's Zero Tolerance Policy, (pg. 13) states that "staff members are subject to disciplinary sanctions up to and including termination of employment for violating SHHRTC sexual abuse or sexual harassment policies". The Executive Director/PREA Coordinator stated during her interview that there have been no staff disciplinary actions taken against staff in the last 12 months for violating the Zero Tolerance policy. A review of the employee files revealed that no staff in the last 12 months had any disciplinary action taken against them for violating the Zero Tolerance policy.

115.376 (b) SHHRTC's Zero Tolerance Policy, (pg. 13) states that "termination of employment is the presumptive disciplinary sanction for staff members who have engaged in sexual abuse". The Executive Director/PREA Coordinator stated during her interview that there have been no staff disciplinary actions taken against staff in the last 12 months for violating the Zero Tolerance policy. A review of the employee files revealed that no staff in the last 12 months had any disciplinary action taken against them for violating the Zero Tolerance policy.

115.376 (c) SHHRTC's Zero Tolerance Policy, (pg. 13) states that "disciplinary sanctions for violations of SHHRTC policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) will be commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. The Executive Director/PREA Coordinator stated during her interview that there have been no staff disciplinary actions taken against staff in the last 12 months for violating the Zero Tolerance policy. A review of the employee files revealed that no staff in the last 12 months had any disciplinary action taken against them for violating the Zero Tolerance policy.

115.376 (d) SHHRTC's Zero Tolerance Policy, (pg. 13) states that "SHHRTC reports the following actions to any relevant licensing bodies:

- Terminations of employment for violations of agency sexual abuse or sexual harassment policies; and
- Resignations by staff members who would have been terminated if they had not resigned.

The Executive Director/PREA Coordinator stated during her interview that there have been no staff disciplinary actions taken against staff in the last 12 months for violating the Zero Tolerance policy. A review of the employee files revealed that no staff in the last 12 months had any disciplinary action taken against them for violating the Zero Tolerance policy.

The facility is in compliance with this standard.

Corrective Action Required: None

Standard 115.377: Corrective action for contractors and volunteers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.377 (a)

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

115.377 (b)

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. SHHRTC Zero Tolerance Policy
c. Resident Files
d. Employee Files
e. Memorandum for Corrective Action for Contractors and Volunteers

Interviews included:

a. Human Resources
b. Executive Director/PREA Coordinator
c. Program Director/PREA Compliance Manager
d. Volunteer

Site Review / Observations:
a. None

115.377(a) SHHRTC Zero Tolerance Policy, (pg. 14) states that "if a contractor or volunteer engages in sexual abuse, SHHRTC will:

- Prohibit the contractor or volunteer from having any contact with SHHRTC resident;
- And report the finding of abuse to any relevant licensing bodies.

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The Executive Director/PREA Coordinator stated during her interview that there have been no contractor and or volunteer disciplinary actions taken against any in the last 12 months for violating the Zero Tolerance policy. A review of the contractor and volunteer files revealed that no contractor or volunteer in the last 12 months had any disciplinary action taken against them for violating the Zero Tolerance policy.

115.377(b) SHHRTC's Zero Tolerance Policy, (pg. 14) states that "if a volunteer or contractor violates SHHRTC sexual abuse or sexual harassment policies but does not actually engage in sexual abuse, SHHRTC takes appropriate remedial measures and considers whether to prohibit further contact with SHHRTC resident". The Executive Director/PREA Coordinator stated during her interview that there have been no contractor and or volunteer disciplinary actions taken against them in the last 12 months for violating the Zero Tolerance policy. A review of the contractor and volunteer files revealed that no contractor or volunteer in the last 12 months had any disciplinary action taken against them for violating the Zero Tolerance policy.

The facility is in compliance with this standard/

Corrective Action Required: None

Standard 115.378: Interventions and disciplinary sanctions for residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.378 (a)

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

115.378 (b)

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

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.378 (c)

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

115.378 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions? ☒ Yes ☐ No

- If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education? ☒ Yes ☐ No

115.378 (e)

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

115.378 (f)

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

115.378 (g)

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. SHHRTC Zero Tolerance Policy
c. Resident Files
d. Employee Files
e. Memorandum on Interventions and Disciplinary Sanctions for Residents

Interviews included:

a. Executive Director/PREA Coordinator
b. Program Director/PREA Compliance Manager
c. Human Resources
d. Intake Staff

Site Review / Observations:
a. N/A

115.378 (a) SHHRTC's Zero Tolerance Policy, (pg. 14) states that states "a resident may be subject to disciplinary sanctions for engaging in sexual abuse only when:

- There is a criminal finding of guilt or an administrative finding that the resident engaged in resident on resident sexual abuse; and
- The discipline is determined through a due process hearing.

The Executive Director/PREA Coordinator stated during her interview that there has been no resident has received disciplinary sanctions against them in the last 12 months for engaging in sexual abuse. violating the Zero Tolerance policy. A review of the resident files revealed that no resident in the last 12 months had any disciplinary sanctions against them for engaging in sexual abuse.

115.378 (b) SHHRTC Zero Tolerance Policy, (pg. 14) states that "any disciplinary sanctions are commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories. The Executive Director/PREA Coordinator stated during her interview that there have been no disciplinary sanctions taken against a resident in the last 12 months for engaging in sexual abuse nor was any resident:

- Denied daily large muscle exercise
- Denied legally required educational programming or special education services
- Denied daily visits from a medical or mental health care clinician
- Denied access to other programs and work opportunities

A review of the resident files revealed that no resident in the last 12 months had any disciplinary sanctions against them for engaging in sexual abuse.

115.378 (c) SHHRTC Zero Tolerance Policy, (pg. 14) states that "when determining what types of sanctions, if any, should be imposed, that SHHRTC would consider whether a resident's mental disabilities or mental illness contributed to his behavior". The Executive Director/PREA Coordinator stated during her interview that there have been no disciplinary sanctions taken against a resident in the last 12 months for engaging in sexual abuse and that she would consider whether a resident's mental disabilities or mental illness contributed to his behavior when imposing disciplinary sanctions.

115.378 (d) SHHRTC's Zero Tolerance Policy, (pg. 14) states the facility does "offer resident abusers counseling and other interventions designed to address and correct underlying reasons or motivations for the abuse. SHHRTC may require participation in such counseling and interventions as a condition of access to behavior-based incentives, but not as a condition to access general programming or education".

During the interview with the Program Director/PREA Compliance Manager who is also a mental health therapist, she indicates that she would offer therapy, counseling, or other intervention services to an offending student as well as to the victim and that such participation in these interventions would not be a condition of access to any reward-based behavior management systems or other behavior-based incentives. She further stated that they do refrain from requiring a resident to participate in these services as a condition to access general programming and educational services.
A review of the resident files revealed that no resident had been offered therapy, counseling or intervention services in the last 12 months.

115.378 (e) SHHRTC's Zero Tolerance Policy, (pg. 14) states "a resident may be disciplined for sexual contact with staff only upon a finding that the staff member did not consent to such contact". During the interview with the Executive Director/PREA Coordinator she stated that no resident had been disciplined in the last 12 months for sexual contact with a staff member that did not consent to such contact. A review of the resident files revealed that no resident had been disciplined in the last 12 months for sexual contact with a staff member that did not consent to such contact.

115.378 (f) SHHRTC's Zero Tolerance Policy (pg. 14) states SHHRTC "may not discipline a resident if the resident made a report of sexual abuse in good faith based upon a reasonable belief that the alleged conduct occurred not constitute falsely reporting an incident of lying, even if an investigation does not establish evidence sufficient to substantiate the allegation". A review of the resident file revealed that no resident had been disciplined in the last 12 months for making a report of sexual abuse in good faith based upon a reasonable belief that the alleged conduct occurred.

115.378 (g) SHHRTC's Zero Tolerance Policy (pg. 14) states that SHHRTC "may also discipline a resident for engaging in prohibited sexual activity that does not meet the definition of abuse". During the interview with the Executive Director/PREA Coordinator she stated that no resident had been disciplined for engaging in prohibited sexual activity that does not meet the definition of sexual abuse. A review of the resident file revealed that no resident had been disciplined in the last 12 months for engaging in prohibited sexual activity that does not meet the definition of abuse.

This facility is in compliance with this standard.

Corrective Action Required: None

MEDICAL AND MENTAL CARE

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.381 (a)

- If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (b)

- If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (c)

- Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law? ☒ Yes ☐ No

115.381 (d)

- Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. SHHRTC Zero Tolerance Policy
c. Resident Files
d. Employee Files
e. Written Institutional Coordination Response Plan
f. Memorandum for Medical and Mental Care for residents

Interviews included:

a. Program Director/PREA Compliance Manager
b. Executive Director/PREA Coordinator
c. Human Resources
d. Intake Staff
e. Random Staff

Site Review / Observations:

a. None

115.381 (a) SHHRTC Zero Tolerance Policy, (pg. 15) states that "if the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, that staff would ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening". During the interview with the Intake staff she stated during her interview that there had been no residents in the last 12 months who indicated a prior sexual victimization in an institutional or community setting during the intake screening. A review of the resident files revealed that no resident who indicated during the intake screening that they had experience prior sexual victimization, whether it occurred in an institutional setting or in the community, was offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening.

115.381 (b) SHHRTC Zero Tolerance Policy, (pg. 15) states that "if the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, that staff would ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening". During the interview with the Intake staff she stated during her interview that there had been no residents in the last 12 months who had previously perpetrated a sexual abuse in an institutional or community setting, as documented during the intake screening, required a referral to medical or mental health practitioner. A review of the resident files revealed that no resident had perpetrated a sexual abuse, whether it occurred in an institutional setting or in the community, was offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening.

115.381 (c) The Executive Director/PREA Coordinator, Program Director/PREA Compliance Manager and the Intake staff all indicated during their interviews that any related sexual victimization or abusiveness that may occur in an institutional setting is strictly limited to mental health practitioners and the administrative management staff as necessary to inform them of treatment plans, security management decisions including housing, bed, work, education, and program assignments, or as otherwise required by federal, state, or local law. A review of the resident files revealed that no resident had any related sexual victimizations or abusiveness that occurred in an institutional setting or in the community, requiring a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. During the interviews with the random staff, they all indicated that they are only informed about a resident's treatment plans and security management decisions as it pertains to housing, bed, work, education and program assignments.

115.381 (d) SHHRTC's Zero Tolerance Policy, (pg. 15) states that "medical and mental health practitioners must obtain informed consent from resident before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18". A review of the resident's files revealed that off of the residents in SHHRTC are under the age of 18 and therefore a mandated by law to report any prior sexual abuse that did not occur in an institutional setting. The Executive Director/PREA Coordinator, Program Director/PREA Compliance Manager and the Intake staff all indicated during their interviews that they are mandated to report sexual abuse of a resident whether it occurred in an institutional setting or in the community.

This facility is in compliance with this standard.

Corrective Action Required: None

Standard 115.382: Access to emergency medical and mental health services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.382 (a)

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

115.382 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362? ☒ Yes ☐ No

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

115.382 (c)

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

115.382 (d)

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. SHHRTC Zero Tolerance Policy
c. Resident Files
d. Memorandum on Access to timely emergency medical and mental health services

Interviews included:

a. Program Director/PREA Compliance Manager
b. Executive Director/PREA Coordinator
c. Intake Staff
d. Random Staff

Site Review / Observations:

a. None

115.382 (a) SHHRTC Zero Tolerance Policy, (pg. 15) states that "resident victims of sexual abuse will receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgement". The Executive Director/PREA Coordinator and the Program Director/PREA Compliance Manager stated during their interviews that a resident victim will receive and be provided timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgement. The Memorandum of Understanding with the SARC substantiated their assertion.

115.382 (b) SHHRTC Zero Tolerance Policy, (pg. 15) states that "If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, staff first responders take preliminary steps to protect the victim and must immediately notify the appropriate medical and mental health practitioner". The Executive Director/PREA Coordinator indicated during her interview that all staff have been trained as first responders who will immediately take steps to protect the victim, contact the Program Director/PREA Compliance Manager and the Harris County Sheriff Department, who would take the victim to the Texas Children's Hospital for medical and mental health care through the Sexual Abuse Resource Center's (SARC) consortium services. During the interviews with the random staff and first responders, they all indicated that when they become aware that of a sexual abuse allegation, they would separate a victim from the perpetrator, contact their supervisor, call the hotline number, call law enforcement and keep the resident near them until their supervisor and law enforcement arrives. SHHRTC reported one allegation of sexual abuse, which was Unfounded, and the records indicated that the staff took immediate steps to protect the alleged victim.

115.382(c) SHHRTC's Zero Tolerance Policy, (pg. 15) states that "Resident are provided timely information about and timely access to emergency contraception and sexually transmitted infection prophylaxis in accordance with professionally accepted standards of care, where medically appropriate". During the interview with the Program Director/PREA Compliance Manager, she stated that the Texas Children's Hospital provision of services through the Sexual Abuse Resource Center's (SARC) consortium would provide timely information about and timely access to emergency contraception and sexually transmitted infection prophylaxis to the resident victim.

A review of the Memorandum of Understanding with the Texas Children's Hospital's provision of services through the Sexual Abuse Resource Center's (SARC) consortium services substantiated her assertion.

115.382 (d) SHHRTC's Zero Tolerance Policy, (pg. 15) states "SHHRTC provides treatment services to the victim without cost and regardless of whether the victim names the abuser or cooperates with any investigation arising from the incident". The Texas Children's Hospital SANE Nurse also indicated during her interview that forensic medical services are provided at no cost to a resident victim. A review of the Memorandum of Understanding with the Texas Children's Hospital's provision of services through the Sexual Abuse Resource Center's (SARC) consortium services supports the SANE nurse's

assertion. The Program Director/PREA Compliance Manager also stated during her interview that the above services are provided at no cost to a resident victim.

This facility is in compliance with this standard.

Corrective Action Required: None

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.383 (a)

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

115.383 (b)

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

115.383 (c)

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

115.383 (d)

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

115.383 (e)

- If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if "all-male" facility. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☐ Yes ☐ No ☒ NA

115.383 (f)

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

115.383 (g)

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

115.383 (h)

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. SHHRTC Zero Tolerance Policy
c. Resident Files
d. Memorandum for Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers

Interviews included:

a. Executive Director/PREA Coordinator
b. Program Director/PREA Compliance Manager
c. Intake Staff
d. Random Staff
e. The SARC representative

Site Review / Observations:

b. None

115.383(a) SHHRTC's Zero Tolerance Policy, (pg. 15) states that "SHHRTC offers medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual

abuse in any prison, jail, lockup, or juvenile facility". The Executive Director/PREA Coordinator indicated during her interview that medical and mental health evaluations and treatment will be provided to all residents who have been victimized by sexual abuse in a juvenile facility.

115.383(b) SHHRTC Zero Tolerance Policy, (pg. 15) states that "the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody". The Executive Director/PREA Coordinator indicated during her interview that residents, as appropriate, would receive follow-up services, treatment plans, and, when necessary, and referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. A review of the resident files indicated that no resident needed follow up services due to a sexual abuse when released from the facility.

115.383(c) SHHRTC's Zero Tolerance Policy, (pg. 15) states that states that "SHHRTC provides such victims with medical and mental health services consistent with the community level of care". The Executive Director/PREA Coordinator that the medical and mental health services that a resident sexual abuse victim would receive is consistent with the community level of care since they would be provided at the Texas Children's Hospital's provision of services through the Sexual Abuse Resource Center's (SARC) consortium.

115.383 (d) SHHRTC is an all-male facility, however in the event of the presence of a transgender male with female genitals, the Executive Director/PREA Coordinator indicated during her interview that a pregnancy test would be appropriate following any sexually abusive vaginal penetration. The SANE nurse at Texas Children's Hospital confirmed that they would offering pregnancy test, providing timely and comprehensive information about and to all lawful pregnancy related medical services, and testing for sexually transmitted infections to a sexual abuse victim resident as part of their protocol.

115.383 (e) SHHRTC is an all-male facility, however in the event of the presence of a transgender male with female genitals, the Executive Director/PREA Coordinator indicated during her interview that a resident would receive timely and comprehensive information about and timely access to all lawful pregnancy related medical services following any sexually abusive vaginal penetration. The SANE nurse at Texas Children's Hospital confirmed that they would offering pregnancy test, providing timely and comprehensive information about and to all lawful pregnancy related medical services, and testing for sexually transmitted infections to a sexual abuse victim resident as part of their protocol.

115.383 (f) SHHRTC Zero Tolerance Policy, (pg. 15) states that "SHHRTC will ensure that tests for sexually transmitted infections are offered, as medically appropriate, to resident victims of sexual abuse while in their facility". The SANE nurse at Texas Children's Hospital confirmed that they would ensure that tests for sexually transmitted infections are offered, as medically appropriate, to resident victims of sexual abuse. A review of the resident files revealed that no resident had been referred to the Texas Children's Hospital for tests for sexually transmitted infections as a sexual abuse victim.

115.383 (g) According to SHHRTC's Zero Tolerance Policy, (pg. 15) states that "SHHRTC provides treatment services to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising from the incident." the Executive Director/PREA Coordinator indicated during her interview that all services received by a resident referred to the Texas Children's Hospital would be at no cost to the resident. A review of the resident files revealed that no resident had been referred to the Texas Children's Hospital for any of their services in the last 12 months. There were no residents in the population to interview who had been referred to the Texas Children's Hospital in the last 12 months.

115.383(h) SHHRTC Zero Tolerance Policy, (pg. 15) states that “SHHRTC attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners”.

The Program Director/PREA Compliance Manager and the Mental Health Practitioner did indicate during their interviews that once they learn or become aware of a known resident on resident abuser’s abuse history, that within 60 days they would refer the resident to mental health practitioners. They also stated that they would conduct a mental health evaluation and offer treatment upon learning of such abuse history. This facility is in compliance with this standard.

Corrective Action Required: None

DATA COLLECTION AND REVIEW

Standard 115.386: Sexual abuse incident reviews

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.386 (a)

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

115.386 (b)

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

115.386 (c)

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

115.386 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No

- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No

- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.386 (e)

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. SHHRTC Zero Tolerance Policy
c. Resident Files
d. Memorandums on Sexual Incident Reviews for 2019

Interviews included:

a. Program Director/PREA Compliance Manager
b. Executive Director/PREA Coordinator
c. Texas Department of Family and Protective Services (TXDFPS)
d. Sexual Abuse Incident Review Team member

Observations included:
a. None

115.386 (a) SHHRTC's Zero Tolerance Policy, (pg. 16) states that "SHHRTC conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded". The Executive Director/PREA Coordinator stated during her interview that a sexual abuse incident review would be conducted at the conclusion of every sexual abuse investigation, including for allegations that are Unsubstantiated, unless the allegation has been determined to be Unfounded. SHHRTC report one allegation for sexual abuse that was investigated administratively and the findings were Unfounded.

Program Director/PREA Compliance Manager did provide memorandums from the Executive Director for the last 12 months indicated that no sexual abuse incident review occurred due to no sexual abuse investigative findings being Unsubstantiated or Substantiated. A review of the resident, employee and investigative records revealed that there were no Unsubstantiated or Substantiated allegation of sexual abuse that occurred in the last 12 months.

115.386 (b) SHHRTC Zero Tolerance Policy, (pg. 16) states that SHHRTC conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, within 30 days, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded. The Program Director/PREA Compliance Manager indicated that there was no sexual abuse incident review in the last 12 months due to having no sexual abuse investigative findings of Unsubstantiated or Substantiated. A review of the resident, employee and investigative records revealed that there were no Unsubstantiated or Substantiated allegation of sexual abuse that occurred in the last 12 months.

115.386 (c) The SHHRTC incident review team includes upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners. The SHHRTC team consists of the following individuals:

a. Executive Director/ PREA Coordinator
b. Program Director/PREA Compliance Manager
c. Supervisor
d. Contracting Mental Health Practitioner

During the interviews with the Program Director/PREA Compliance Manager and a member of the Incident Review Team, they stated that once a meeting would convene, that input would be provided by them regarding how to prevent further incidents of sexual abuse and sexual harassment from occurring. A review of the resident, employee and investigative records revealed that there were no Unsubstantiated or Substantiated allegation of sexual abuse that occurred in the last 12 months.

115.386(d) SHHRTC Zero Tolerance Policy, (pg. 16) states that SHHRTC would:

- Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse.
- Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility.
- Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse.
- Assess the adequacy of staffing levels in that area during different shifts.
- Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff.
- Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA Compliance Manager.

The Program Director/PREA Compliance Manager did provide memorandums for the last 12 months indicating that no sexual abuse incident review occurred due to no sexual abuse investigative findings being Unsubstantiated or Substantiated.

115.386 (e) SHHRTC Zero Tolerance Policy, (pg. 16) states that "SHHRTC would submit a report of its findings to the Executive Director and other appropriate staff to implement the recommendations for improvement, or document its reasons for not doing so". The Program Director/PREA Compliance Manager did provide memorandums for the last 12 months indicating that no sexual abuse incident review occurred due to no sexual abuse investigative findings being Unsubstantiated or Substantiated, therefore no recommendations for any improvement were required.

This facility is in compliance with this standard.

Corrective Action Required: None

Standard 115.387: Data collection

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.387 (a)

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

115.387 (b)

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

115.387 (c)

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

115.387 (d)

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

115.387 (e)

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

115.387 (f)

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. SHHRTC Zero Tolerance Policy
c. Memorandum regarding data collection

Interviews included:

a. Program Director/PREA Compliance Manager
b. Executive Director/PREA Coordinator

Observations included:

Agency web site www.shamarhopehaven.org.

115.387(a) SHHRTC's Zero Tolerance Policy, (pg. 16) states that "SHHRTC collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. The Program Director/PREA Compliance Manager indicated during her interview that they do collect accurate data on every allegation from facilities under their control using a standardized instrument and set of definitions. They currently have only had one Unfounded sexual abuse allegation in the last 12 months and have placed this data on a spreadsheet for future reporting purposes.

115.387 (b) SHHRTC Zero Tolerance Policy, (pg. 16) states that "SHHRTC collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions and aggregates the data at least once each year". During the interviews with the Executive Director/PREA Coordinator and the Program Director/PREA Compliance Manager it was ascertained that they had not aggregated this incident annually that occurred in calendar year of 2019 nor for the last 3 years. This facility is not in compliance with this provision.

115.387 (c) The Executive Director/PREA Coordinator and the Program Director/PREA both indicated during their interviews that they do not participate in the Survey of Sexual Violence conducted by the Department of Justice (DOJ) but if they did, their incident based data would include the data necessary to answer the questions on the said survey.

115.387 (d) The Executive Director/PREA Coordinator and the Program Director/PREA both indicated during their interviews that they would and do maintain, review, and collect data as needed from available incident-based documents, including reports, investigation files and sexual abuse incident reviews. They further indicated that the data collected thus far, though not in a report format but provided verbally to this auditor, came from the report and the one investigation file in the last 12 months.

115.387 (e) The Executive Director/PREA Coordinator and the Program Director/PREA both indicated during their interviews that they do not contract for the confinement of their residents with another private facility.
115.387 (f) The Executive Director/PREA Coordinator and the Program Director/PREA both indicated during their interviews that they would provide, upon request, all such data from the previous calendar year to the Department of Justice no later than June 30. They further stated that DOJ has not requested agency data in the last 3 years as well as in the 12 months.

Corrective Action Required: SHHRTC must collect and aggregate all sexual abuse data at least once a year, create an annual report and post that report on the agency's website in order to be in compliance with this standard.

Corrective Action Response: SHHRTC did provide to this auditor a memorandum from the Executive Director stating that they do and will continue to collect and aggregate all sexual abuse data at least once a year, that they do and have completed an annual report for 2019 and have posted that report on the agency's website. The annual report was observed as being posted on the agency's website.

This facility is in compliance with this standard.

Standard 115.388: Data review for corrective action

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.388 (a)

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

115.388 (b)

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

115.388 (c)

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

115.388 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. SHHRTC Zero Tolerance Policy

Interviews included:

a. Executive Director/ PREA Coordinator
b. Program Director/PREA Compliance Manager

Site Review / Observations:

a. Agency web page: www.shamarhopehaven.org

115.388 (a) The Program Director/PREA Compliance Manager stated during her interview that she has and would review any and all data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by:

- Identifying problem areas

- Taking corrective action on an ongoing basis.

She stated that she had not collected nor prepared an annual report for 2019 of her findings nor recommended corrected action for each house. She further stated that the during the previous 3 years there were no sexual abuse and sexual harassment allegations. The facility is not in compliance with this provision.

115.388 (b) The Program Director/PREA Compliance Manager stated during her interview although she did not complete an annual report for 2019, once she does, the comparison of the current year's data and corrective actions, which were none, with those from prior years would provide an assessment of the agency's progress in addressing sexual abuse. The facility is not in compliance with this provision as indicated per 115.388 (a).

115.388 (c) The Program Director/PREA Compliance Manager stated during her interview that although she did not complete an annual report for 2019, once she does, the annual report would be approved by the Executive Director and made readily available to the public though the agency's website. The facility is not in compliance with this provision as indicated per 115.388 (a).

115.388 (d) The Program Director/PREA Compliance Manager stated that during her interview that although she did not complete an annual report for 2019, once she does, the annual report would indicate the nature of the material redacted and where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility. The facility is not in compliance with this provision as indicated per 115.388 (a).

Corrective Action Required: SHHRTC must develop, have the Executive Director approve, sign, then post on the agency website the 2019 Annual Report that compares aggregated incident data reflecting the one Unfounded sexual abuse allegation of the past 12 months, comparing it to the previous year's data, including any recommended corrective actions and or improvements to be implemented in order to be in compliance with this provision.

Corrective Action Response: SHHRTC did provide to this auditor proof documentation in the form of the 2019 Annual Report which was approved by the Executive Director. That report did compare the aggregated incident data, reflecting the one Unfounded sexual abuse allegation of the past 12 months, with the previous year's data, inclusive of any recommended corrective actions and or improvements to be implemented during this reporting period.

This facility is in compliance with this standard.

Standard 115.389: Data storage, publication, and destruction

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.389 (a)

- Does the agency ensure that data collected pursuant to § 115.387 are securely retained?
  ☒ Yes ☐ No

115.389 (b)

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

115.389 (c)

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

115.389 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. Shamar Hope Haven RTC Zero Tolerance Policy

Interviews included:

a. Executive Director/PREA Coordinator
b. Program Director/PREA Compliance Manager

Site Review / Observations:
a. Agency web page: www.shamarhopehaven.org

115.389 (a) SHHRTC's Zero Tolerance Policy states, (pg. 16) that the "SHHRTC will collect and retain sexual abuse and sexual harassment data in a secure manner". The Program Director/PREA Compliance Manager indicated during her interview that all sexual abuse and sexual harassment data collected will be securely retained pursuant to 115.387. She further stated that this information is securely retained in the Executive Director's office under lock and key.

115.389 (b) The Program Director/PREA Compliance Manager indicated during her interview that all aggregated sexual abuse data, from facilities under its direct control, though they do not contract for confinement of their residents to another private facility, would be readily available to the public at least annually through the agency's website once the 2019 annual report is completed and approved by the Executive Director. This agency is not in compliance with this provision.

115.389 (c) The Program Director/PREA Compliance Manager stated during her interview that although she did not complete an annual report for 2019, once she does, she would remove all personal identifiers before making the aggregated sexual abuse data available to the public though the agency's website. The facility is not in compliance with this provision as indicated per 115.388 (a).

115.389 (d) The Program Director/PREA Compliance Manager stated during her interview SHHRTC would maintain all sexual abuse data collect pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise.

Corrective Action Required: SHRTC must make the annual report aggregate sexual abuse data including removing all personal identifiers before making it available to the public on the agency's website in order to be in compliance with this provision

Corrective Action Response: SHRTC did provide to this auditor a copy of the 2019 Annual Report of aggregate sexual abuse data which reflected the removal of all personal identifiers before making it available to the public on the agency's website.

This facility is in compliance with this standard.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.401 (a)

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

115.401 (b)

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

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

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

115.401 (h)

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

115.401 (l)

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

115.401 (m)

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

115.401 (n)

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. Final PREA Report dated 2/9/2017

Interviews included:

a. Executive Director/PREA Coordinator
b. Program Director/PREA Compliance Manager

Site Review / Observations:
a. Agency web page: www.shamarhopehaven.org

115.401(a) The Program Director/PREA Compliance Manager stated during her interview that the Truxillo and Wheeler House was audited at least once in June/July of 2016.

115.401 (b) The Program Director/PREA Compliance Manager stated during her interview that this is the first year of the current audit cycle.

115.401 (h) During the onsite phase of this audit this auditor did have access to, and the ability to observe, all areas of SHHRTC's administrative building, Truxillo and Wheeler houses.

115.401 (l) During the onsite phase of this audit this auditor was permitted to request and receive copies of any relevant document including electronically stored information from SHHRTC's administrative files and records, including from Truxillo and Wheeler houses.

115.401 m. During the onsite phase of this audit this auditor was able to conduct interviews with the residents in a private setting (e.g. an office with a door)

115.401 n. During the pre-audit, onsite and post-audit phase of this audit, residents were and are permitted to send confidential information or correspondence to this auditor in the same manner as if they were communicating with legal counsel. As of the writing of this report, this auditor has not received any confidential information or correspondence from a resident and or staff from Truxillo or Wheeler house to date.

This facility is in compliance with this standard.

Corrective Action Required: None

Standard 115.403: Audit contents and findings

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. The pendency of any agency appeals pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. Final PREA Report dated 2/9/2017

Interviews included:

a. Executive Director/PREA Coordinator
b. Program Director/PREA Compliance Manager

Site Review / Observations:

a. Agency web page: www.shamarhopehaven.org

115.403 (f) A review of SHHRTC's website revealed that they were previously audited in June/July of 2016. The dates of the facility visit were June 29- July 1st, 2016. A Final PREA Audit Report was issued by Certified PREA Auditor Jerome K Williams on February 9, 2017. A review of SHHRTC's website revealed that the only link regarding a PREA Report for this timeframe was to the Interim Report, of which could not be opened. The Executive Director was informed of this point and the requirement not to post the Interim Report but only the Final Report on the website. She indicated that her webmaster made an error in the posting of this report but it will be corrected. This facility is not in compliance with this standard.

Recommendation: Once this audit is completed and the Final Report issued, SHHRTC must ensure that this report is posted on the website with a link that will open it, within 60 days of its issuance.

Corrective Action Required: SHHRTC must repost the 2017 Final Report on their website within 60 days of receipt of this report and it is to remain there for 10 years in order to be in compliance with this standard.

Corrective Action Response: This auditor did review SHHRTC website and noticed that the 201 Final Report was reposted on their website and was assured that it will remain there for 10 years.

This facility is in compliance with this standard.

AUDITOR CERTIFICATION

I certify that:

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

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

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

Jerome K. Williams August 24, 2020

Auditor Signature **Date**