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

☐ Interim ☒ Final

Date of Report November 7, 2019

Auditor Information

Name: Dave Cotten	**Email:** dave@preaauditing.com
Company Name: PREA Auditors of America	
Mailing Address: 14506 Lakeside View Way	**City, State, Zip:** Cypress, TX 77429
Telephone: 713-818-9098	**Date of Facility Visit:** March 6 & 7, 2019

Agency Information

Name of Agency: West Texas Behavioral Health Residential Treatment Center (BHRTC)		**Governing Authority or Parent Agency** *(If Applicable)*: El Paso County (TX) Community Supervision and Corrections Department	
Physical Address: 3700 Mattox		**City, State, Zip:** El Paso TX 79925	
Mailing Address: Click or tap here to enter text.		**City, State, Zip:** Click or tap here to enter text.	
Telephone: 915-772-8537		**Is Agency accredited by any organization?** ☒ Yes ☐ No	
The Agency Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☒ State	☐ Federal

Agency mission: To Promote Public Safety and Re-socialize the Offender. To provide a comprehensive community supervision model that promotes public safety by using cross-system collaborations with law enforcement and community-based interventions to reduce the risk of future criminal behavior. Interventions include a complete range of progressive sanctions, incentives, community-based behavioral health, human services, and restorative justice.

Agency Website with PREA Information: none

Agency Chief Executive Officer

Name: Magdalena Morales-Aina, LPC-S	**Title:** Director
Email: MmAina@epcounty.com	**Telephone:** 915-546-8120

Agency-Wide PREA Coordinator

Name: Belinda D. Hernandez, LCDC, LPC	**Title:** Residential Director
Email: behernandez@epcounty.com	**Telephone:** 915-772-8537
PREA Coordinator Reports to: Annalisa Davila, Deputy Director	**Number of Compliance Managers who report to the PREA Coordinator** 0

Facility Information

Name of Facility:	West Texas Behavioral Health Residential Treatment Center
Physical Address:	3700 Mattox El Paso Texas 79925
Mailing Address (if different than above):	
Telephone Number:	915-772-8537

The Facility Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☒ State	☐ Federal

Facility Type:	☒ Community treatment center	☐ Halfway house	☐ Restitution center
	☐ Mental health facility	☐ Alcohol or drug rehabilitation center	
	☐ Other community correctional facility		

Facility Mission: To Promote Public Safety and Re-socialize the Offender. To provide a comprehensive community supervision model that promotes public safety by using cross-system collaborations with law enforcement and community-based interventions to reduce the risk of future criminal behavior. Interventions include a complete range of progressive sanctions, incentives, community-based behavioral health, human services, and restorative justice.

Facility Website with PREA Information: none

Have there been any internal or external audits of and/or accreditations by any other organization? ☒ Yes ☐ No

Director

Name: Magdalena Morales-Aina, LPC-S	**Title:** Director
Email: MmAina@epcounty.com	**Telephone:** 915-546-8120

Facility PREA Compliance Manager

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

Facility Health Service Administrator			
Name:	Belinda Hernandez, LPC	**Title:**	Assistant Director
Email:	behernandez@epcounty.com	**Telephone:**	915-772-8537

Facility Characteristics

Designated Facility Capacity: 120	**Current Population of Facility:** 96
Number of residents admitted to facility during the past 12 months	295
Number of residents admitted to facility during the past 12 months who were transferred from a different community confinement facility:	0
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 30 days or more:	295
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:	295
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:	0

Age Range of Population:	☒ Adults	☐ Juveniles	☐ Youthful residents
	18 +	Click or tap here to enter text.	Click or tap here to enter text.

Average length of stay or time under supervision:	Based on clinical assessment
Facility Security Level:	Minimum
Resident Custody Levels:	Minimum
Number of staff currently employed by the facility who may have contact with residents:	44
Number of staff hired by the facility during the past 12 months who may have contact with residents:	Click or tap here to enter text.
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	1

Physical Plant

Number of Buildings: One	**Number of Single Cell Housing Units:** 0
Number of Multiple Occupancy Cell Housing Units:	16
Number of Open Bay/Dorm Housing Units:	0

Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.):

Overall the camera system covers most hallways and common areas. There are cameras in the rooms but not in the shower/toilet area. Residents are told to not be in a state of undress within the room and must go to the shower/toilet area to dress or undress.

Medical

Type of Medical Facility: **None**	Click or tap here to enter text.
Forensic sexual assault medical exams are conducted at:	Sierra Medical Center

Other	
Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:	0
Number of investigators the agency currently employs to investigate allegations of sexual abuse:	0

Audit Findings

Audit Narrative

The auditor's description of the audit methodology should include a detailed description of the following processes during the pre-onsite audit, onsite audit, and post-audit phases: documents and files reviewed, discussions and types of interviews conducted, number of days spent on-site, observations made during the site-review, and a detailed description of any follow-up work conducted during the post-audit phase. The narrative should describe the techniques the auditor used to sample documentation and select interviewees, and the auditor's process for the site review.

The on-site PREA Audit of the West Texas Behavior Health Resident Treatment Center (BHRTC) was conducted on March 6 & 7, 2019 The audit was conducted by Dave Cotten, a certified National PREA auditor under contract with PREA Auditors of America, LLC to conduct this audit. This is BHRTC's first National PREA Audit. Approximately six weeks prior to the on-site visit, BHRTC posted notifications of the upcoming audit with the auditor's contact information to allow for residents to contact the auditor prior to the audit. The auditor received one correspondence from a resident and that resident was interviewed. BHRTC provided the auditor with file documentation electronically approximately two weeks prior to the on-site visit. From this documentation, the auditor completed as much of the auditor compliance tool as possible prior to the on-site visit. The file documentation provided was minimal and lacked sufficient information to indicate policy/document compliance. It was apparent the facility had not properly prepared for the audit process and/or had not been properly prepared by the governing body. As will be noted in the following compliance report, numerous corrective actions were required with some requiring a corrective action period to complete and some to show a pattern of compliance.

The auditor did contact the Texas Association Against Sexual Assault who, upon research, reports no incidents of sexual abuse have been recorded or noted for the BHRTC.

An initial in-brief was held at 9:00 a.m. on 3/6/19 with Director Magdalena Morales-Aina, Deputy Director Annalisa Davila, CCF Assistant Director Belinda Hernandez and Case Manager Supervisor Jimena Canales. Staff introduced themselves and provided professional background as did the auditor. The Director provided the auditor with an overview of the BHRTC and the resident population it serves. The auditor was given a complete tour of the facility. Throughout the tour, the auditor observed the notices of this PREA audit in all the buildings, as well as posters that called attention to the facility's Zero Tolerance Policy and how to report allegations of sexual abuse and sexual harassment. Some staff toilet areas, where residents access for classes or meeting with case managers, counselors, etc.., were found to be not lockable from the outside or were not key operated so could be locked from the inside, but not accessible from the outside even with a key. Recommendations were made to place staff key operated locks on the staff toilet areas. Auditor also noticed several counselor office doors did not have windows allowing for persons to be inside the office undetected or actions not visible. Recommendation made for installation of door windows for further resident and staff protection. Following the tour, the auditor began the interviews and reviews of on-site documents.

Sixteen (16) residents were interviewed. Thirteen of those interviewed were randomly selected, by the auditor, from a list of all the offenders by their housing assignment at the facility. Two residents were interviewed who identified as gay. One of those residents also reported having reported sexual abuse, however he stated it was actually sexual harassment. The other resident who identified as gay was also LEP. One offender who reported previous sexual abuse at screening was also interviewed. One resident who had communicated with the auditor prior to the on-site was interviewed.

Twelve random staff were interviewed who were randomly selected by the auditor from all shifts. Two of those staff were also interviewed as 1st Responders as all security staff (monitors) are considered 1st Responders. Ten (10) interviews were conducted with specialized staff. On-site interviews included the Facility Director, PREA Coordinator/Manager, a counselor for mental health referrals, the human resources manager, staff who conduct screening for risk of abuse or victimization, an incident review team member, and first responders. Phone interviews were conducted with the Agency Head & SANE representative after the on-site visit.
The auditor also interviewed one contractor. In total, 22 staff/contractor/volunteer interviews were conducted as part of the audit.
It should be noted that since this is a small facility, some of the employees have multiple responsibilities so some individuals were interviewed more than once if their duties covered more than one specialized area.

The auditor was impressed by what the random staff's knowledge of PREA, the zero-tolerance policy, and resident rights regarding PREA. First responder duties and evidence collection/security were limited although apparent they had received the training, there had been no call for experience. The facility would benefit from the use of carry cards to refer to and tabletop or exercise drills to allow for experience.

When the on-site audit was completed, the auditor conducted a short de-brief on March 7, 2019 with Ms. Davila, Ms. Hernandez and Ms. Canales. The auditor gave an overview of the audit and thanked the Director and her staff for their commitment to the Prison Rape Elimination Act.

Facility Characteristics

The auditor's description of the audited facility should include details about the facility type, demographics and size of the inmate, resident or detainee population, numbers and type of staff positions, configuration and layout of the facility, numbers of housing units, description of housing units including any special housing units, a description of programs and services, including food service and recreation. The auditor should describe how these details are relevant to PREA implementation and compliance.

West Texas Behavioral Health Residential Treatment Center BHRTC is a 120-bed adult re-entry facility housing both male and female adult residents based on commitment directed by county and district judges through the probation department. The average daily population is 96-110 for the last twelve months with 69 male residents and 28 female residents (97 total) on the first day of the on-site. BHRTC is comprised of a single building housing residents in 16 multi occupancy rooms. Female and male residents are not allowed to intermingle and are separated by locked, staff only operated door. There is a separate program area building for classes.

The facility does have a perimeter fence with drive through gates that are controlled by coded key pad or remotely by 24 hours a day manned control center. Entry to the building is controlled by staff keys or remotely. Entry into the administrative area is also staff controlled by key of remotely.

The facility, as a community corrections, has no on-site medical services and no on-site criminal investigators. An administrative investigator was trained during the corrective action period as noted in the applicable standards below.

Overall the camera system is very good with cameras covering most hallways and common area. There are cameras in the rooms but not in the shower/toilet area. Residents are told to not be in a state of undress within the room and must go to the shower/toilet area to dress or undress. Auditor did identify an area needing camera coverage or direct staff supervision in the outbuilding used for group classes.

Except in emergency circumstances, only male staff work in the male resident area and only female staff work in the female resident area.

Summary of Audit Findings

*The summary should include the number of standards exceeded, number of standards met, and number of standards not met, **along with a list of each of the standards in each category**. If relevant, provide a summarized description of the corrective action plan, including deficiencies observed, recommendations made, actions taken by the agency, relevant timelines, and methods used by the auditor to reassess compliance.*

Auditor Note: *No standard should be found to be "Not Applicable" or "NA". A compliance determination must be made for each standard.*

Number of Standards Exceeded: one (1)

115.215

Number of Standards Met: Thirty-one (31)

115.211, 115.212, 115.215, 115.216, 115.218, 115.231, 115.232, 115.233, 115.234, 115.235, 115.241, 115.242, 115.251, 115.254, 115.261, 115.262, 115.263, 115.264, 115.265, 115.266, 115.267, 115.271, 115.272, 115.273, 115.276, 115.277, 115.278, 115.282, 115.283, 115.286, 115.401

Number of Standards Not Met: Nine (9)

115.213, 115.217, 115.221, 115.222, 115.252, 115.253, 115.287, 115.288 & 115.289

Summary of Corrective Action (if any)

Due to numerous standards not originally meeting standard, the facility was under a corrective action plan (CAP) not to exceed 180 days from the submission of the interim report to the facility on April 19th, 2019. The final report must be submitted to the facility and the Department of Justice through the PREA Resource Center prior to November 16, 2019 to allow for the CAP completion date of October 16, 2019 and 30 days to file the report. However, the final report can be filed at anytime prior to that should the agency/facility show it meets all elements of all standards. As noted below at least one corrective action required a "pattern of compliance" to show the facility meets the standard consistently over a given period of time. Actions taken and final findings on each of the corrective actions listed in this summary are addressed in each individual standard.

The agency and/or facility had corrective actions in nineteen (19) separate standards as listed below and provided to the facility in the interim report on April 19, 2019. Many of the issues needing addressed were discussed in person, on the phone or via e-mail prior to and after the interim report was submitted.

West Texas Behavioral Health Treatment Center addressed ten (10) of those standards to meet standard. Of the remaining nine (9), some were partially addressed but not to the point of fully meeting the standard and some were not addressed.

115.213-- **Corrective Action:** BHRTC needs to provide a written staffing plan addressing all elements of standard 115.213 section (a) and provide verification of any deviations to the staffing plan or file documentation that no deviations occurred. Facility staff are referred to the PREA Resource Center's white paper on "Developing and Implementing a PREA-Compliant Staffing Plan"

115.217-- **Corrective Action:** BHRTC needs to provide completed background check documents, "Employment Application Supplemental" forms, "Conditions of Employment" forms, or other documents ensuring all elements of the standard are met and a data base or roster of completed employee background checks (initial and less than every 5 years) and a roster or data base reflecting background checks of volunteers and contractors.

115.221-- **Corrective Actions:** (1) MOUs (or attempts at securing MOUs) for local law enforcement, SANE and victims' advocate are needed for compliance. (2) Identified staff are to complete training as required for administrative investigators. Upon completion, the facility is to contact the auditor to set up an interview with the newly trained investigator(s).

115.222-- **Corrective actions:** The agency/facility needs to provide on its website or, if it does not have one, through other means: a policy and practice 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. Provide auditor with verification of completion.

115.234-- **Corrective actions:** The facility needs to provide certificate for administrative investigator upon successful completion of training as outlined in element (b) of the standard. Auditor will interview that staff upon completion of the specialized training.

115.241--**Corrective Actions:** Per discussion with the auditor, to establish a pattern of compliance (which has not occurred in the past) the facility will:
(1) develop and implement a screening tool to address all elements of this standard;
(2) re-assess all current residents using the newly developed screening tool to address all elements of this standard for initial risk screening. Evaluate each for risk of victimization and abusiveness using the information to address standard 115.242;
(3) begin using the newly developed screening tool to screen all new arrival residents using the information to address standard 115.242 and
(4) using the newly developed screening tool or similar tool/method to reassess all new arrival residents within 30 days of completion of the initial screening tool.
Facility will notify the auditor when the newly developed screening tool(s) are developed and the process implemented.
Facility will notify the auditor when all current residents have been screened using the newly developed tool and provide the auditor with a current resident roster.
Between the 1st and the 5th day of the month following the above implementation, the facility will provide the auditor with a resident roster and a roster of all the previous month's new arrival residents. For the following three months between the 1st and 5th, the facility will provide a list of all new arrival residents for the previous month.
Auditor will identify random residents from above rosters and require completed initial assessments and/or re-assessments for those residents.

Facility will supply required documents by posting to the secure portal and notifying the auditor when documents are uploaded.
When a pattern of compliance of meeting all elements of this standard is established (as determined by the auditor) the auditor will notify the facility. After implementation, a minimum of 90 to 120 days of compliance is required.

115.242—**Corrective actions:** Ensure compliance with the elements of this standard during implementation and upon completion of standard 115.241.

115.251-- **Corrective action:** Provide at least one way for residents to (privately) report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency. The agency/facility is referred to the PREA Resource Center FAQ on standard 115.51(251) for the parameters.

115.252-- **Corrective actions:** (1) Develop and implement policy/procedure for residents to file emergency grievances as outlined in element (f) of this standard. Provide this information to residents. (2) Address in policy and provide the information to residents: 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.

115.253-- **Corrective Action:** (1) Provide residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses along with the current telephone numbers. (2) Though postings or handbook provide residents with 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. (3) Develop and request MOU with community agencies providing emotional support.

115.254-- **Corrective Action:** (1) Develop or add to policy the procedure for 3rd party reporting. (2) Post publicly (website or other) how to report sexual abuse and sexual harassment on behalf of a resident. The agency/facility is referred to the PREA Resource Center FAQs on 115.54.

115.265-- **Corrective action:** The facility needs to develop and institute a facility specific coordinated response plan as defined in this standard.

115.267-- **Corrective Action:** Facility needs to add periodic status checks to monitoring of residents for retaliation or, should the facility elect to develop a checklist for retaliation monitoring, include periodic status checks in the checklist.

115.271-- **Corrective action:** (1) The facility needs to provide completion certificate for administrative investigator upon successful completion of training as outlined in element (b) of the standard. (2) The facility needs to provide an MOU or attempts at an MOU with local law enforcement to investigate sexual abuse allegation.

115.282-- **Corrective actions:** (1) Develop and implement an MOU with local medical agency or organization to perform SANE/SAFE and medical treatment as outlined in the standard. Attempts to enter into the agreements, whether accomplished or not, are to be provided to the auditor. (2) Add element (c) of the standard to the policy and to the noted MOU.

115.283-- **Corrective Actions:** The facility/agency needs to provide documentation that they (or through MOU):

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; to 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;

Provide such victims with medical and mental health services consistent with the community level of care.

Offer pregnancy tests to resident victims of sexually abusive vaginal penetration while incarcerated and if pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services.

Offer resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate

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

115.287-- **Corrective actions:** The agency/facility needs to develop, implement and provide to the auditor annual reports for 2017 and 2018 to address each element of this standard. Provide the auditor with documentation verifying this information is publicly posted.

115.288-- **Corrective actions:** The agency/facility needs to develop, implement and provide to the auditor annual reports for 2017 and 2018 to address each element of standard 115.287. Provide the auditor with policy or other documentation verifying the elements of this standard (115.288) are addressed from the information gathered to include a comparison (element b) of the last two years. Show documentation of the annual report being posted publicly (element c).

115.289-- **Corrective action:** See corrective actions for 115.287 and 115.288, then address all elements of this standard.

PREVENTION PLANNING

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

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

115.211 (a)

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

115.211 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy: El Paso County Community Supervision and Corrections Department Behavioral Health Residential Center (BHRTC), PREA Policy outlines PREA policy to include a zero-tolerance policy for sexual misconduct and sexual harassment to include definitions. It states:
"PREA COVERAGE
A. The El Paso County Community Supervision and Corrections Department (CSCD-BHRTC) - Behavioral Health Residential Center is committed to providing a safe and healthy environment for clients, staff, visitors, contractors and volunteers. The CSCD-BHRTC is committed to protecting clients from sexual abuse and sexual harassment. Sexual abuse and sexual harassment compromise the safety of everyone in our Department and will not be tolerated. The center's policy will serve as a mechanism for complying with the Prison Rape Elimination Act (PREA) and the PREA National Standards. [15.21I (a), 115.262)
B. The Department has mandated a zero-tolerance policy relating to any sexual misconduct and sexual harassment between staff, volunteers, contractors, and clients or their family members. All allegations, regardless of the source, of coercive, or consensual sexual misconduct/harassment occurring among clients will be fully investigated, sanctioned (if authority to do so exists), and referred for prosecution if the prohibited conduct violates state criminal laws.
C. The Prison Rape Elimination Act (PREA) covers incidents involving staff, clients, volunteers, and collateral contacts.
1. Prohibited behaviors include, but are not limited to the following: touching, hugging, kissing, sexual assault, penetration, fondling, inappropriate viewing, sexual conduct, sexual harassment,

sexual abuse, sexual gratification, romantic relationships, relationships between staff/clients, volunteers/clients or outside the agency involvement between staff and client.
2. Client on Client Sexual Abuse: Sexual contact between clients without the client's consent, or in which the client is unable to consent or refuse.
3. Staff Sexual Misconduct: Any behavior or act of a sexual nature whether it be consensual or nonconsensual
directed toward a client by an employee, volunteer, contractor, visitor or other agency representative. Termination from employment shall be the presumptive disciplinary sanction for staff who engaged in sexual misconduct."

Other documentation: Organization chart showing Belinda Hernandez at the PREA Coordinator/Manager.

Interviews: Ms. Hernandez states she has sufficient time to administer PREA for the agency/facility, but not in an 8-hour day. She described her actions to coordinate the efforts to meet the elements of the standards, thereby addressing sexual abuse/harassment of residents. She states she has the authority to ensure many updates and changes as needed and has a good working relationship with executive staff to recommend others.

Findings: The facility meets the elements of this standard.

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

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

115.212 (a)

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

115.212 (b)

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents OR the response to 115.212(a)-1 is "NO".) ☐ Yes ☐ No ☒ NA

115.212 (c)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Not applicable as BHRTC does not contract for the confinement of residents.

Standard 115.213: Supervision and monitoring

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

115.213 (a)

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

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

- Does the agency ensure that each facility's staffing plan takes into consideration the physical layout of each facility in calculating adequate staffing levels and determining the need for video monitoring? ☐ Yes ☒ No

- Does the agency ensure that each facility's staffing plan takes into consideration the composition of the resident population in calculating adequate staffing levels and determining the need for video monitoring? ☐ Yes ☒ No

- Does the agency ensure that each facility's staffing plan takes into consideration the prevalence of substantiated and unsubstantiated incidents of sexual abuse in calculating adequate staffing levels and determining the need for video monitoring? ☐ Yes ☒ No

- Does the agency ensure that each facility's staffing plan takes into consideration any other relevant factors in calculating adequate staffing levels and determining the need for video monitoring? ☐ Yes ☒ No

115.213 (b)

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

115.213 (c)

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

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

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy: On 10/16/19, the facility provided policy requiring the development of a staffing plan.

Other documentation: Memo addressing the audit states the facility has had no deviations from the staffing plan.

Observations and Interviews: The BHRTC readily admits to not having a staffing plan and therefore not tracking any deviations from the staffing plan.

Initial Findings: The facility does not meet the standard. No documentation was provided to verify elements (a) or (b) above. While there are annual reviews reportedly conducted, there is no written staffing plan and no indication that there were any deviations to the staffing plan or if deviations did occur, no documentation or justifications.

Corrective Action: 115.214--BHRTC needs to provide a written staffing plan addressing all elements of standard 115.213 section (a) and provide verification of any deviations to the staffing plan or file documentation that no deviations occurred. Facility staff are referred to the PREA Resource Center's white paper on "Developing and Implementing a PREA-Compliant Staffing Plan"

Action taken: While the facility provided policy requiring the development and adherence to the staffing plan, no specific staffing plan was provided. A memo to the audit states they have had no deviations to the current staffing plan (not available).

Final Findings: While the facility did provide policy requiring the development and adherence to a staffing plan, the facility does not meet this standard as no Staffing Plan was provided. For development of a compliant staffing plan, the facility is again referred to the PREA Resource Center's white paper on "Developing and Implementing a PREA-Compliant Staffing Plan" which outlines the requirements as: "There are four PREA requirements imposed for all facility types: The development of a staffing plan must include an assessment of adequate staffing levels and, where applicable, video monitoring along with a set of prescribed specific considerations, with the goal of preventing sexual abuse; The plan must be documented; The facility must document and provide justification, if required, whenever there is a deviation from the staffing plan; and The facility must document on an annual (or more frequent) basis the assessment of the staffing plan and document any needed adjustments to the plan."

Community confinement facilities and lockups: When developing a staffing plan, community confinement facilities and lockups are mandated to consider:
(1) The physical layout of each lock up [or] facility; (2) The composition of the detainee [or] resident population; (3) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and (4) Any other relevant factors.

A PREA-compliant staffing plan is a written document that reflects the results of an objective analysis of the facility's staffing needs to ensure sexual safety. The staffing plan must identify the personnel and any video monitoring technology necessary to safely and securely operate a facility in a manner that protects against sexual abuse. The staffing plan must describe the numbers and types of positions and video monitoring equipment needed, and the manner in which they would be deployed within each facility to meet the facility's mission to protect inmates, detainees, or residents from sexual abuse.

Standard 115.215: Limits to cross-gender viewing and searches

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

115.215 (a)

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

115.215 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches of female residents, except in exigent circumstances? (N/A if less than 50 residents)
- ☒ Yes ☐ No ☐ NA

- Does the facility always refrain from restricting female residents' access to regularly available programming or other outside opportunities in order to comply with this provision? (N/A if less than 50 residents) ☒ Yes ☐ No ☐ NA

115.215 (c)

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

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

115.215 (d)

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

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

115.215 (e)

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

- If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that

information as part of a broader medical examination conducted in private by a medical practitioner? ☒ Yes ☐ No

115.215 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy: BHRTC PREA policy states all searches will be conducted by staff of the same sex and searches of transgender/intersex residents will be completed by a staff member of the same sex for which the residents has been classified by the referring agency. Policy also states: "Clients may shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine living quarter checks." & "Searches or physical examination of a transgender or intersex client for the sole purpose of determining the client's genital status is prohibited." Policy requires staff of the opposite gender to announce themselves when entering an area where residents are likely to be showering, performing bodily functions, or changing clothes.

Other documentation: Power point presentation compiled by the Moss Group titled "Guidance in Cross-gender and transgender pat Searches"
Examples of training sign in logs for the above training from 2018 and 2019.

Interviews and observations: The facility director states there have been no such searches conducted requiring documentation. All random staff stated they have never seen a female resident have to wait for a female staff to search them when required. Staff also know they would not search a resident to determine their genital status. Random staff know to announce themselves when entering

the living unit area of opposite gender residents. Random residents interviewed stated they generally hear staff of the opposite gender announce themselves. No residents felt they were ever in a position that they had to be in a state of undress, use the toilet or shower with staff of the opposite gender viewing them. All staff indicated they had recently received training on cross gender and transgender/intersex searches.

Findings: The agency/facility exceeds this standard with very good policy, good training and very good practice in all searches completed by staff of the same sex, staff announcements and comments from staff or residents verifying policy and practice are followed.

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

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

115.216 (a)

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

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

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

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

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

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

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

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

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

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

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

115.216 (b)

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

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

115.216 (c)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy: BHRTC PREA policy states:
A. During the intake/orientation process, all clients shall receive information regarding sexual abuse prevention and reporting in a manner that is understandable regardless of individual limitations explaining: (115.233 (a)-l(b)). All clients, even those who have transferred from another Department, shall receive comprehensive educational information about the following:
1. The agency's zero-tolerance policy regarding sexual abuse and sexual harassment;
2. How to safely report incidents, threats or suspicions of sexual misconduct/harassment;
3. their rights to be free from sexual misconduct and retaliation for reporting such incident (l1s.233(a));
4. Agency policies and procedures for responding to such incidents; and
5. Consequences of false allegations.

Policy goes on the describe how staff are required to meet all the elements of this standard using verbiage from the standard itself. The facility does use a Client PREA Acknowledgement Form.

Other documentation: Client PREA Acknowledgement Form.

Interviews and observations: One resident was identified as LEP during the random resident interviews. A translator was provided for the auditor. The resident stated he was given all the PREA information through a staff translator and he was knowledgeable of the PREA information as he completed the questions asked. The agency director stated the agency provides Spanish speaking staff and will ensure all residents receive the information in a format they can understand which includes one on one interaction with counselors to confirm the resident's understanding. Random staff generally knew they are never to use another resident to translate after the initial report if it occurs that way.

It should be noted that it appears this facility employees more bi-lingual (English/Spanish) than English only speaking staff.

Findings: Based on policy and interviews, the facility meets the elements of this standard.

Standard 115.217: Hiring and promotion decisions

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

115.217 (a)

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

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

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

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

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

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

115.217 (b)

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

115.217 (c)

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

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

115.217 (d)

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

115.217 (e)

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

115.217 (f)

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

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

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

115.217 (g)

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

115.217 (h)

- Unless prohibited by law, does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.) ☒ Yes ☐ 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*)

Instructions for Overall Compliance Determination Narrative

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

Policy: BHRTC PREA policy pages 4 & 5 addresses all elements of this standard. With verbiage from the standard itself.

Other documentation: On October 16, 2019, the facility provided a roster of employee background checks.

Interviews and observations: The agency uses a system called "flash notification" which reportedly notifies the agency should any of their assigned staff have a law enforcement contact of any kind. The deputy director states all personnel and contractors/volunteers are given background checks upon hire or entry and are completed annually. Any known incidents would be cause for not hiring or termination.

Initial Findings: Although policy addresses each element, based on the lack of additional information, the agency/facility does not meet the standard as no documents were provided to reflect compliance with the elements.

Corrective Action: BHRTC needs to provide completed background check documents, "Employment Application Supplemental" forms, "Conditions of Employment" forms, or other documents ensuring all elements of the standard are met and a data base or roster of completed employee background checks (initial and less than every 5 years) and a roster or data base reflecting background checks of volunteers and contractors.

Final findings: While the facility provided a list of employees with when the background checks were completed, many of the dates are well out of the five-year requirement. Additionally, no information was provided on contractor/volunteer background checks, no completed "Employment Application Supplement" or "Conditions of Employment" forms as requested in the above corrective action. The agency/facility does not meet the elements of this standard.

Standard 115.218: Upgrades to facilities and technologies

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

115.218 (a)

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

115.218 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Interviews and observations: In discussions with the director and the PREA Coordinator, the camera system has been upgraded mostly due to PREA concerns such as blind spots.

Findings: Based on the above interviews, the facility meets this standard.

RESPONSIVE PLANNING

Standard 115.221: Evidence protocol and forensic medical examinations

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

115.221 (a)

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

115.221 (b)

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

- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is

not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.221 (c)

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

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

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

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

115.221 (d)

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

- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? ☒ Yes ☐ No

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

115.221 (e)

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

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

115.221 (f)

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

115.221 (g)

- Auditor is not required to audit this provision.

115.221 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.221(d) above.) ☒ 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*)

Instructions for Overall Compliance Determination Narrative

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

Policy: BHRTC PREA policy addresses each of the above elements

Interviews and observations: Of the random staff interviewed all knew the local police were responsible for investigating sexual abuse at the facility. Most staff were aware of securing the scene, reporting, isolating the victim and encouraging the victim to not do anything that could compromise evidence, such as changing clothes, showering, drinking anything, etc..,

Initial findings: The facility does not meet the standard as addressed in the corrective action below.

Corrective Actions: (1) MOUs (or attempts at securing MOUs) are needed for local law enforcement, SANE and victims' advocate are needed for compliance. (2) Identified staff are to complete training, as required above, for administrative investigators. Upon completion, the facility is to contact the auditor to set up an interview with the newly trained investigator.

Action taken: BHRTC did provide a certificate of training from the NIC's website for the administrative investigator.

Final findings: The facility did not provide documentation of MOUs (or attempts at entering into MOUs) with local law enforcement, SANE/SAFE or victim advocates. Per the PREA Resource Center's FAQs "Under standard 115.21, the agency (a private, federal, state, county, or other local

entity) being audited must demonstrate to the auditor that it has attempted to gain compliance from an external entity that conducts criminal investigations of sexual abuse with requirements (a) through (e) of that standard—that is, the agency being audited must have requested that the external entity responsible for investigations comply with all those provisions described in (a) through (e) of standard 115.21.

Auditors may find that the private, federal, state, county, or other local entity being audited has attempted to confirm that an external investigator is complying with (a) through (e) of the standard and was unable to get such confirmation. In that case, the agency being audited can be found compliant with the standard, if they have documented these efforts: and,

the agency's (BHRTC) policy requires "Whenever feasible, the Department shall enter into a written Memorandum of Understanding (MOU) with the outside agency investigating agency or entity outlining the roles and responsibilities of both the Department and the investigating entity in performing sexual abuse investigations."

As noted in the paragraph from the standard below, the agency shall document its efforts to provide SAFE or SANE and victim advocates.
(c) The agency shall offer all victims of sexual abuse access to forensic medical examinations whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The agency shall document its efforts to provide SAFEs or SANEs.
(d) The agency shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the agency shall make available to provide these services a qualified staff member from a community-based organization or a qualified agency staff member. Agencies shall document efforts to secure services from rape crisis centers.

While the facility did address corrective action (2) by the administrative investigator completing the required training on October 15th, 2019, the facility did not contact the auditor to set up the required interview as noted in the corrective action.

The facility does not meet the elements of this standard.

Standard 115.222: Policies to ensure referrals of allegations for investigations

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

115.222 (a)

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

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

115.222 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to

conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? ☒ Yes ☐ No

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

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

115.222 (c)

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

115.222 (d)

- Auditor is not required to audit this provision.

115.222 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy: BHRTC PREA policy addresses each of the above elements except (b) with nothing showing publicly posting the information on a website or other public method.

Interviews and observations: The agency head states all allegations are referred to local law enforcement for investigation. If not criminal, it would be referred back to her office for assignment to the facility administrative investigator.

Initial finding: The facility does not meet the standard as no evidence of public posting was provided or was found by the auditor.

Corrective actions: The agency/facility needs to provide on its website or, if it does not have one, through other means: a policy and practice 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. Provide auditor with verification of completion.

Action taken: None noted

Final finding: The facility does not meet the standard as it did not provide information on: "The agency shall publish such policy on its website or, if it does not have one, make the policy available through other means." as noted in the standard.

TRAINING AND EDUCATION

Standard 115.231: Employee training

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

115.231 (a)

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in confinement? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The common reactions of sexual abuse and sexual harassment victims? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? ☒ Yes ☐ No

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

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

115.231 (b)

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

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

115.231 (c)

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

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

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

115.231 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does

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

Policy: BHRTC PREA policy pages 5 & 6 outlines elements (a) & (c) of this standard well, to include requiring all staff to complete the training at least every two years.

Other documentation: Power point training for PREA as adapted from the Moss Groups training. Training certificates of completion.

Interviews and observations: This facility houses both male and female residents therefore staff are trained appropriately for supervision of both genders. All random staff interviewed were knowledgeable of required training. As with most facilities having minimal experience in responding to sexual abuse in confinement settings, training and education is the limit of their knowledge. The facility would benefit from table-top or real time exercises to develop some experience.

Findings: The agency/facility meets the elements of this standard.

Standard 115.232: Volunteer and contractor training

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

115.232 (a)

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

115.232 (b)

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

115.232 (c)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy: BHRTC PREA policy states:
Volunteers and contractors will be trained and acknowledge by electronic or manual signature, their understanding of the received training. Training shall include their responsibilities under the agency's zero-tolerance policy of sexual misconduct/harassment prevention, detection, reporting and responding;
1. Signed documentation will be maintained in the volunteer or contractor's fie. (115.232
2. Volunteers/contractors who have contact with clients on a recurring basis shall be provided a copy of this policy prior to admission to the Department to begin their assignment or task.
3. The PREA Acknowledge of Understanding form serves as verification of the volunteers or contractor's review and understanding of the contents of this policy and shall be completed by each volunteer or contractor who has contact with clients on a recurring basis. A newly signed PREA Acknowledgement of Understanding form will be required for future revisions of this policy.

Other documentation: Power point of the Moss Group's PREA training overview. Contractor training rosters provided.

Interviews and observations: One contractor was interviewed stating they had received PREA training in the last few months. Contractor described portions of the training to include zero tolerance, how to report to staff, supervisors, local law enforcement, PREA hotline and organizations such as CASFU and Emergence. The facility reports no volunteers currently access the facility.

Findings: Based on the above policy, training materials and noted interviews the facility meets the elements of this standard.

Standard 115.233: Resident education

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

115.233 (a)

- During intake, do residents receive information explaining: The agency's zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining: How to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No

- During intake, do residents receive information explaining: Their rights to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No

- During intake, do residents receive information explaining: Their rights to be free from retaliation for reporting such incidents? ☒ Yes ☐ No

- During intake, do residents receive information regarding agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

115.233 (b)

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

115.233 (c)

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

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

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

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

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

115.233 (d)

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

115.233 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy: BHRTC PREA policy addresses elements (a) through (e) using verbiage from the standard itself.

Other documentation: Client handbook covers zero tolerance, right to free from sexual abuse/harassment and how to report.
Two separate PREA Acknowledgement of Understanding forms addresses zero tolerance, reporting methods and phone numbers, facility responses to abuse, and confidential counseling contact numbers. The most recent form is in English and Spanish.
PREA poster (English, large print and Spanish) addresses zero tolerance, how to report to include contact persons and phone numbers; and confidential counseling contact numbers for Center Against Sexual and Family Violence (CASFV).

Interviews and observations: Interview with intake staff indicates all residents receive an intake packet containing the handbook and PREA acknowledgement forms, they watch the PREA orientation video from the Resource Center and the issues is discussed with questions as needed. Intake always happens within 72 hours.
Almost all residents interviewed stated they had received PREA information upon arrival and at least once since. They were aware of the posters and the handbook information.
One LEP resident was interviewed and stated he did receive the information in a manner he could understand.

Findings: Based on PREA policy, resident handbook and other documentation as well as the residents interviews and knowledge of PREA, that facility meets the elements of this standard.

Standard 115.234: Specialized training: Investigations

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

115.234 (a)

- In addition to the general training provided to all employees pursuant to §115.231, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators 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 115.221(a).] ☒ Yes ☐ No ☐ NA

115.234 (b)

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

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

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

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

115.234 (c)

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

115.234 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy: BHRTC PREA policy states all allegations are reported to local law enforcement and at least two staff will be trained in PREA investigations (for administrative) and outlines the required training to meet elements (b) and (c).

Other documentation: Administrative investigator NIC training certificate provided during the CAP.

Interviews and observations: In interviewing the facility director and agency director, the facility does not currently have a trained administrative investigator. One staff will be assigned to complete the training via the PREA Resource Center website. All allegations that indicate criminal activity are referred to local law enforcement.

Initial findings: The facility is not compliant as they have no one trained in sexual abuse investigations in confinement settings.

Corrective actions: The facility needs to provide certificate for administrative investigator upon successful completion of training as outlined in element (b) of the standard.

Action taken: As noted in “other documentation” above, the facility provided a certificate of completion for the investigator date October 15, 2019.

Final findings: With the actions taken as noted above, the facility meets the elements of this standard.

Standard 115.235: Specialized training: Medical and mental health care

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

115.235 (a)

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? ☐ Yes ☒ No
- 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? ☐ Yes ☒ No
- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to victims of sexual abuse and sexual harassment? ☐ Yes ☒ No
- 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? ☐ Yes ☒ No

115.235 (b)

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

115.235 (c)

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? ☐ Yes ☒ No

115.235 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? ☐ Yes ☐ No

- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? [N/A for circumstances in which a particular status (employee or contractor/volunteer) does not apply.] ☐ 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*)

Instructions for Overall Compliance Determination Narrative

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

Policy: BHRTC PREA page 6 policy requires mental health professionals receive specialized training and define the elements of this standard.

Interviews and observations: The facility has no medical or mental health staff who work at the facility. Residents are referred to local clinics. All counselors at the facility are specific to substance abuse.

Findings: As the facility has no medical or mental health staff who work at the facility, no elements of this standard are applicable. Therefore, the facility will show as meeting the standard.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.241: Screening for risk of victimization and abusiveness

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

115.241 (a)

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

115.241 (b)

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

115.241 (c)

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

115.241 (d)

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has a mental, physical, or developmental disability? ☒ Yes ☐ No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The age of the resident? ☒ Yes ☐ No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The physical build of the resident? ☒ Yes ☐ No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously been incarcerated? ☒ Yes ☐ No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident's criminal history is exclusively nonviolent? ☒ Yes ☐ No

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

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

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

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

115.241 (e)

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

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

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

115.241 (f)

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

115.241 (g)

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

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

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

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

115.241 (h)

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

115.241 (i)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy: BHRTC PREA policy requires all residents be screened as outlined in elements a, b, c, g, f, h and I of the standard.

Other documentation: Sexual Victimization and Abusiveness form did not initially address each element of the standard for assessment of risk. An updated risk assessment was completed and is being used.

Interviews and observations: Staff readily acknowledged they have not screened for abusiveness. With no means of identifying those at risk of victimization and those at risk of abusiveness, the facility can not effectively keep separate residents to meet elements of standard 115.242 below.

Initial findings: Does not meet the standard. The facility has a screening tool and has policy to address the standard but has not screened for abusiveness addressing element (e).

Corrective Actions: Per discussion with the auditor, to establish a pattern of compliance (which has not occurred in the past) the facility will (1) develop and implement a screening tool to address all elements of this standard; (2) re-assess all current residents using the newly developed screening tool to address all elements of this standard for initial risk screening. Evaluate each for risk of victimization and abusiveness using the information to address standard 115.242; (3) begin using the newly developed screening tool to screen all new arrival residents using the information to address standard 115.242 and (4) using the newly developed screening tool or similar tool/method to reassess all new arrival residents within 30 days of completion of the initial screening tool.
Facility will notify the auditor when the newly developed screening tool(s) are developed and the process implemented.
Facility will notify the auditor when all current residents have been screened using the newly developed tool and provide the auditor with a current resident roster.
Between the 1st and the 5th day of the month following the above implementation, the facility will provide the auditor with a resident roster and a roster of all the previous month's new arrival residents.
Auditor will identify random residents from above rosters and require completed initial assessments and/or re-assessments for those residents.
Facility will supply required documents by posting to the secure portal and notifying the auditor when documents are uploaded.
When a pattern of compliance of meeting all elements of this standard is established (as determined by the auditor) the auditor will notify the facility. After implementation, minimum of 90 to 120 days of compliance is required.

Action taken: (1) On 6/28/19, the facility notified the auditor that all current residents had been re-assessed using the newly created assessment tool.
The facility provided the auditor with rosters for all current residents and the auditor selected random residents to review. The facility provided appropriate risk assessments for those residents.
For the following three months the facility provided a list of identifying all newly assigned residents for the previous months. The roster includes the date the initial assessment is completed and the date of the 30 re-assessment.

Final findings: Based on the agency/facility providing assessments and reassessments that meet the requirements of this standard, as outlined in the corrective action, over a 90 to 120 day period to establish a pattern of compliance, the facility now meets the elements of this standard.

Standard 115.242: Use of screening information

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

115.242 (a)

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

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

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

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

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

115.242 (b)

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

115.242 (c)

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

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

115.242 (d)

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

115.242 (e)

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

115.242 (f)

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: lesbian, gay, and bisexual residents in dedicated facilities, units, or wings solely on the basis of such identification or status? ☒ Yes ☐ No

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: transgender residents in dedicated facilities, units, or wings solely on the basis of such identification or status? ☒ Yes ☐ No

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status? ☒ 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 narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy: PREA policy states: Upon admission or no later than24 hours to the Department, and upon transfer to another Department, clients shall be screened by staff assigned to perform the initial intake screening process in order to obtain information relevant to:
4. Housing, counseling and groups with the goal of keeping separate those clients at high risk of being sexually victimized from those at high risk of being sexually abusive; and
5. Identify past victims and./or predators and assess vulnerability to sexual abuse victimization.
Policy identifies the Clinical Supervisor, Residential Monitor Supervisor, CM Supervisor and Deputy Director as the persons to determine placement based on any risk factors being identified.
Policy further address elements (c), (d), (e) & (f).

Other documentation: Risk assessment form and data base reflecting actions needed for specific residents based on those risk assessments.

Interviews and observations: Staff readily acknowledged they have not screened for abusiveness. With no means of identifying those at risk of victimization and those at risk of abusiveness, the facility cannot effectively keep separate residents to meet elements of this standard. This was corrected during the CAP as noted below.

Initial findings: While policy addresses each all elements except (a), the facility is not compliant as noted in standard 115.241 above.

Corrective action: Ensure compliance with the elements of this standard during implementation and upon completion of standard 115.241.

Action taken: (1) On 6/28/19, the facility notified the auditor that all current residents had been re-assessed using the newly created assessment tool.
The facility provided the auditor with rosters for all current residents and the auditor selected random residents to review. The facility provided appropriate risk assessments for those residents.
For the following three months the facility provided a list of identifying all newly assigned residents for the previous months. The roster includes the date of the initial assessment is completed and the date of the 30 re-assessment and includes actions needed for specific residents based on the risk assessments.

Final findings: Based on the agency/facility providing assessments and reassessments that meet the requirements of standard 115.241, as outlined in the corrective action, over a 90 to 120 day period to establish a pattern of compliance; and identifying actions needed for high risk residents, the facility now meets the elements of this standard.

REPORTING

Standard 115.251: Resident reporting

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

115.251 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? ☒ Yes ☐ No

115.251 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No
- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No
- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No

115.251 (c)

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

115.251 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy: BHRTC PREA policy addresses both resident and staff reporting. Staff are required to immediately report any incidents/allegations of sexual abuse, harassment, retaliation, staff neglect or violations of responsibilities. Per policy, staff may report privately to the agency head or the administration department.

Other documentation: Client handbook with contact numbers and persons. Posters in the facility.

Interviews and observations: Auditor observed posters throughout with methods of reporting, but none to a public or private entity not part of the agency.
Interviews with staff and residents indicate all are trained or educated on reporting methods.

Initial findings: Does not meet standard. While several methods of reporting are posted, none could be found in the file or posted or otherwise presented to the residents to address element (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; Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials; Does that private entity or office allow the resident to remain anonymous upon request? Policy states residents can call TDCJ-CJAD which refers to the Texas Department of Criminal Justice,

Community Justice Assistance Division. Policy has the phone number, but number is not readily available to residents.

Corrective action: Provide at least one way for residents to (privately) report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency. The agency/facility is referred to the PREA Resource Center FAQ on standard 115.51(251) for the parameters.

Action taken: The facility provided an updated resident handbook, dated 10/16/19, which provides phone numbers to the Texas Department of Criminal Justice PREA Ombudsman office, the El Paso Sheriff's Office (Crime Victims Services) and the Center Against Sexual and Family Violence (CASFV) and the CASFV Sexual Assault Services Coordinator.

Final findings: With actions taken, as noted above, the facility now meets the elements of this standard.

Standard 115.252: Exhaustion of administrative remedies

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

115.252 (a)

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

115.252 (b)

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

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

115.252 (c)

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

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

115.252 (d)

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

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

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

115.252 (e)

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

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

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

115.252 (f)

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

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

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

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

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

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

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

115.252 (g)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy: BHRTC PREA policy provided in file addresses elements (a) through (e) with verbiage from the standard except the term "sexual misconduct" is used rather than "sexual abuse".

Interviews and observations: Several random residents stated interviewed knew they could use the grievance system to report sexual abuse.

Findings: Does not meet standard. Elements (f) and (g) are not addressed in the file provided. Nothing if file to address the filing of an emergency grievance or procedures for the filing of a grievance in bad faith or the disciplinary result.

Corrective actions: (1) Develop and implement policy/procedure for residents to file emergency grievances as outlined in element (f) of this standard. Provide this information to residents. (2) Address in policy and provide the information to residents: 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.

Final findings: As no action to the corrective action was provided to the auditor, the final findings are the facility does not meet the standard.

Standard 115.253: Resident access to outside confidential support services

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

115.253 (a)

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

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

115.253 (b)

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

115.253 (c)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Other documentation: Posters with phone number for Center Against Sexual and Family Violence (CASFV). Note: Address was added during the CAP.

Interviews and observations: A phone call to CASFV indicated they do provide emotional support for sexual abuse victims.

Initial findings: Does not meet standard. Elements are not addressed. No addresses could be found for agencies that would provide emotional support for sexual abuse victims. No evidence of information provided to residents on 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. No evidence presented to indicate MOUs have been initiated with agencies for victim advocates or other agencies to provide emotional support to victims.

Corrective Action: (1) Provide residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses along with the current telephone numbers. (2) Though postings or handbook provide residents with 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. (3) Develop and request MOU with community agencies providing emotional support.

Action taken: (1) & (2) The facility provided an updated resident handbook, dated 10/16/19, which provides a phone number and address for the Center Against Sexual and Family Violence (CASFV) and phone numbers for the CASFV Sexual Assault Services Coordinator and two Outreach Victim Advocates. The handbook also addresses the confidentiality and mandatory reporting. Policy was provided which states "D. Clients will be informed prior to access the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to the authorities in accordance with mandatory reporting laws." (3) No action noted.

Final findings: While the agency/facility addressed elements (1) & (2) of the corrective actions, no documentation was provided to address corrective action (3) or the related element of this standard:
(c) The agency shall 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. The agency shall maintain copies of agreements or documentation showing attempts to enter into such agreements.
The facility, therefore, does not meet all the elements of this standard.

Standard 115.254: Third-party reporting

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

115.254 (a)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Other documentation: Client handbook informs residents on how to report through a third party.

Interviews and observations: Nothing in file. Most random residents did not understand third party reporting. Most staff were aware of the third-party reporting option for residents.

Initial findings: Does not meet standard. Although no written policy was found in the file, residents are informed through the client handbook. The agency/facility has not provided the information publicly on how to report sexual abuse and sexual harassment on behalf of a resident.

Corrective Action: (1) Develop or add to policy the procedure for 3rd party reporting. (2) Post publicly (website or other) how to report sexual abuse and sexual harassment on behalf of a resident. The agency/facility is referred to the PREA Resource Center FAQs on 115.54.

Actions taken: During the CAP, the facility updated policy to provide for 3rd party reporting to include a website, www.epcounty.com/EPCS/ for a form called "community grievance' and phone # and address which can be used to report third party. Information is also available in the updated resident handbook.

Final findings: Based on the action taken, as noted above, the agency/facility now meets the elements of this standard.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.261: Staff and agency reporting duties

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

115.261 (a)

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

115.261 (b)

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

115.261 (c)

- Unless otherwise precluded by Federal, State, or local law, are medical and mental health practitioners required to report sexual abuse pursuant to paragraph (a) of this section? ☒ Yes ☐ No
- Are medical and mental health practitioners required to inform residents of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services? ☒ Yes ☐ No

115.261 (d)

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

115.261 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy: BHRTC PREA policy pages 12 & 13 addresses all elements of this standard with verbiage from the standard.

Interviews and observations: All random staff interviewed stated they were required to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment 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. Mental health staff interviewed stated they were mandatory reporters and were required to inform residents of their limitations.

Findings: Based on the above policy and interviews conducted the facility meets the elements of this standard.

Standard 115.262: Agency protection duties

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

115.262 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy: BHRTC PREA policy page 12 addresses this.

Other documentation:

Interviews and observations: All random staff interviewed stated they were to separate and protect the potential victim. The Director and the PREA coordinator stated, depending on the circumstances, a resident at imminent risk would be separated and could be moved to another area of the facility or removed from the facility. Investigation would immediately ensue.

Findings: Based on policy and the above interviews, the facility meets the elements of this standard.

Standard 115.263: Reporting to other confinement facilities

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

115.263 (a)

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

115.263 (b)

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

115.263 (c)

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

115.263 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy: BHRTC PREA policy page 14 addresses the elements.

Interviews and observations: In interviews with the PREA Coordinator and the Facility Director, notification would be made and follow up would occur.

Initial findings: Does not meet standard. Policy directs the PREA Coordinator to make the notification with no mention of the Facility Head directing the notification to occur.
From the PREA Resource Center FAQs:
The notification must, at a minimum, be: (1) Made at the direction of the facility head, and (2) Appear to a third party to have originated with the facility head. For example, the facility head could instruct his or her administrative assistant to send the notification on the facility head's letterhead and with the facility head's signature, or to send the notification from the facility head's email address. By contrast, the facility's PREA Compliance Manager could not send the notification from his or her email address and merely copy the facility head.
The intent of the standard is to ensure that the person receiving the report of sexual abuse at the prior facility understands the seriousness and gravity of the allegation, and that the communication originated at the highest level of the reporting facility.

Corrective Action: Adjust policy to wording similar to the wording from the FAQ of 115.263 on the PRC website that 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 notification is made by the facility head or at the direction of or originating from the facility head.

Action taken: No action was required as the policy statement to address this standard was found in another file by the auditor.

Final findings: The agency/facility meets the standard as the policy statement was found in another file, not the one provided, that addresses this standard.

Standard 115.264: Staff first responder duties

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

115.264 (a)

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

115.264 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy: BHRTC PREA policy pages 13 & 14 address the elements. With verbiage from the standard.

Other documentation:

Interviews and observations: Interviews with random staff indicate most staff have a good working knowledge or first responder duties. As with most small facilities, all security staff are first responders. Staff interview specifically as first responders also had good knowledge. There were no residents who had reported sexual abuse to interview. Recommend first responder cards be carried by all assigned security staff.

Findings: Based on policy as written and interviews with random staff and first responders, the facility meets the elements of this standard.

Standard 115.265: Coordinated response

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report
115.265 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Other documentation: BHRTC specific Coordinated Response Plan provided during the CAP.

Interviews and observations: The facility has no coordinated response plan.

Initial findings: Does not meet standard. The facility has no coordinated response plan.

Corrective action: The facility needs to develop and institute a facility specific coordinated response plan as defined in this standard.

Action taken: The facility provided a coordinated response plan which meets the elements of this standard.

Final findings: With the actions taken above to address the elements of this standard, the facility now meets this standard.

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

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

115.266 (a)

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

115.266 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Interviews and observations: Per an interview with the facility head and PREA coordinator, the facility does not engage in collective bargaining or other agreements that could limit 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.

Findings: Facility meets this standard.

Standard 115.267: Agency protection against retaliation

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

115.267 (a)

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

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

115.267 (b)

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

115.267 (c)

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

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

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

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

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

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

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

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

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

115.267 (d)

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

115.267 (e)

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

115.267 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy: BHRTC PREA policy page 20 states:
A. Retaliation against clients. employees. or other parties for reporting sexual misconduct

will not be tolerated. Those who retaliate may face disciplinary action up to and including unsuccessful discharge for clients and dismissal for employees. Protection measures by the DEPARTMENT include but are not limited to the following:
1. Housing changes or transfer for client victims or abuser;
2. Removal of alleged staff or client abusers from contact with victims;
3. Emotional support services will be provided for clients or staff who fear retaliation for reporting sexual misconduct or for cooperating with investigations;
4. Monitor the conduct and treatment of clients or staff who reported the sexual misconduct, any individual expressing a fear of retaliation, and of clients who were reported to have suffered sexual misconduct to see if there are changes that may suggest possible retaliation for at least 90 days;
5. Promptly act to remedy any such retaliation, included but not limited to:
(A) Client disciplinary reports;
(B) Housing changes;
(C) Program changes;
(D)Negative performance reviews of staff; and/or
(E) Reassignment of staff.
6. Continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need; and the obligation to monitor shall terminate if the allegation is determined to be unfounded.

Interviews and observations: In interviewing the PREA coordinator, should the need occur, she would follow the policy. Auditor recommends a checklist specific to retaliation monitoring to ensure all elements are addressed.

Initial findings: Does not meet standard. Policy does not address element (d) which requires monitoring to include periodic status checks with the resident.

Corrective Action: Facility needs to add periodic status checks to monitoring of residents for retaliation or, should the facility elect to develop a checklist for retaliation monitoring, include periodic status checks in the checklist.

Action taken: The facility updated policy to include “Client monitoring will also include periodic status checks.

Final findings: With the action taken as noted above, the facility now meets all elements of this standard.

INVESTIGATIONS

Standard 115.271: Criminal and administrative agency investigations

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

115.271 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not

responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA

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

115.271 (b)

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

115.271 (c)

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

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

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

115.271 (d)

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

115.271 (e)

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

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

115.271 (f)

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

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

115.271 (g)

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

115.271 (h)

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

115.271 (i)

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

115.271 (j)

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

115.271 (k)

- Auditor is not required to audit this provision.

115.271 (l)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy: BHRTC PREA policy pages 16 – 18 addresses administrative and criminal investigations to include elements related to administrative investigations and cooperative efforts with criminal investigations.

Other documentation: Added during CAP—Certificate of Completion for Administrative Investigator.

Interviews and observations: The facility completes only sexual harassment cases not deemed to be criminal. Therefore, elements addressing criminal investigation do not apply.

Initial findings: Does not meet standard. (1) The assigned administrative investigator has not completed training as defined in element (b) of the standard. (2) Per BHRTC policy requiring whenever feasible, the department shall enter into a written MOU with the outside agency. There is no MOU or evidence of efforts to enter into an MOU with local law enforcement for criminal investigations.

Corrective action: (1) The facility needs to provide completion certificate for administrative investigator upon successful completion of training as outlined in element (b) of the standard. (2) The facility needs to provide an MOU or attempts at an MOU with local law enforcement to investigate sexual abuse allegation.

Action taken: (1) The assigned administrative investigator did provided a certificate of completion for NIC's PREA investigator's training. (2) No action has been noted.

Final findings: Due to the actions above, the agency/facility meets the elements of this standard. While corrective action (2) has not been addressed, nothing in the standard or FAQs specifically requires an MOU, or attempts in enter into an agreement, with local law enforcement for this standard as they do for standard 115.221. While meeting the standard, best practice is to address an agreement with local law enforcement and abide by the written policy of BHRTC.

Standard 115.272: Evidentiary standard for administrative investigations

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

115.272 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy: BHRTC PREA policy page 18 addresses this with "In any sexual abuse or sexual harassment investigation in which the Department is the primary investigating entity, the Department shall utilize a preponderance of the evidence standard for determining whether sexual abuse or sexual harassment has taken place.

Findings: Based on the noted policy, the facility meets this standard.

Standard 115.273: Reporting to residents

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

115.273 (a)

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

115.273 (b)

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

115.273 (c)

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

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

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

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

115.273 (d)

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

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

115.273 (e)

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

115.273 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy: BHRTC PREA policy, pages 18 and 19 outline the elements of this standard using verbiage directly from the standard.

Interviews and observations: The facility has not had a case requiring notifications. Interviews with the PREA Coordinator and facility head, both stated this would happen per policy.

Findings: Based on the above policy, the facility meets this standard.

DISCIPLINE

Standard 115.276: Disciplinary sanctions for staff

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

115.276 (a)

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

115.276 (b)

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

115.276 (c)

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

115.276 (d)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy: BHRTC PREA policy is written using verbiage directly from the standard and states:
Employees shall be subject to disciplinary sanctions up to and including termination for violating Department sexual abuse or sexual harassment policies. Termination shall be the presumptive disciplinary sanction for employees who have engaged in sexual abuse. (1rs.276 (a)(b))
J. Disciplinary sanctions for violations of Department sexual abuse or sexual harassment policies (other than actually engaging in sexual abuse) shall be commensurate with the nature and circumstances of the acts committed, the employee's disciplinary history, and the sanctions imposed for comparable offenses by other employees with similar histories. (rrs.276 (c))
K. All terminations for violations of the Department sexual abuse or sexual harassment policies, or resignations by employees who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. (l15.276 (d))
L. Any civilian or contractor who engages in sexual abuse shall be prohibited from contact with clients and shall be reported to law enforcement agencies and to any relevant licensing body. Any other violation of the Department sexual abuse or sexual harassment policies by a civilian or contractor will result in further prohibitions. (115.277 (aXb))
M. Once the investigation is complete, the necessity of keeping the victim and perpetrator separated will be evaluated, such that the victim and perpetrator or potential perpetrator are kept separate while housed at the Department (or until any recommended transfer is completed).

Other documentation: Termination letter for person violating PREA policy. No residents were involved in the incident.

Interviews and observations: Interviews with agency head, facility head and human resources staff confirmed the policy has been followed and would be for any future events.

Findings: Based on the policy and other documentation noted, and the interviews, the facility meets the standard.

Standard 115.277: Corrective action for contractors and volunteers

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

115.277 (a)

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

115.277 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy: BHRTC PREA policy is written using verbiage directly from the standard and states:
L. Any civilian or contractor who engages in sexual abuse shall be prohibited from contact with clients and shall be reported to law enforcement agencies and to any relevant licensing body. Any other violation of the Department sexual abuse or sexual harassment policies by a civilian or contractor will result in further prohibitions. (115.277 (a)(b))
M. Once the investigation is complete. the necessity of keeping the victim and perpetrator separated will be evaluated, such that the victim and perpetrator or potential perpetrator are

kept separate while housed at the Department (or until any recommended transfer is completed).

Interviews and observations: Interviews with facility head and PREA coordinator indicate any volunteer or contractor alleged to have violated any part of the PREA policy would be removed immediately pending investigation. Investigative process would then determine further actions, and policy would be followed regarding banning, reporting to law enforcement and licensing bodies. The facility has had no cases of this occurring.

Findings: Based on the above policy and interviews, the facility meets this standard.

Standard 115.278: Interventions and disciplinary sanctions for residents

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

115.278 (a)

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

115.278 (b)

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

115.278 (c)

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

115.278 (d)

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

115.278 (e)

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

115.278 (f)

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

115.278 (g)

- 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*)

Instructions for Overall Compliance Determination Narrative

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

Policy: Facility policy states:
DISCIPLINARY PROCEDURE
A. All clients found guilty of sexual abuse shall be institutionally disciplined in accordance with the Department disciplinary procedures. (1 15.278 (a))
B. Because the burden of proof is substantially easier to prove in a client's disciplinary case than in a criminal prosecution, a client may be institutionally disciplined even though law enforcement officials decline to prosecute.
C. Sanctions shall be commensurate with the nature and circumstances of the abuse committed, the client's disciplinary history, and the sanctions imposed for comparable offenses by other clients with similar histories. (l 15.278 (b))
D. The disciplinary process shall consider whether a client's mental disabilities or mental illness contributed to his/her behavior when determining what type of sanction, if any, should be imposed. (l15.278 c)
E. A client may be disciplined for sexual conduct with an employee only upon finding that the employee did not consent to such contact. (1 15.278 (e))
F. Clients who deliberately allege false claims of sexual abuse can be disciplined.

G. The Department Director or designee should contact law enforcement to determine if a deliberately false accusation may be referred for prosecution.
H. If the Department offers therapy, counseling, or other interventions designed 1o address and correct underlying reasons or motivations for the abuse, the Department shall consider whether to require the alleged perpetrator to participate in such interventions as a condition of access to programming or other benefits. (115.278 (d))

Interviews and observations: Interviews with facility head and PREA coordinator indicate the client disciplinary process would be used, but they have had no substantiated cases which required action. Any substantiated cases of sexual abuse would result in termination from the program and the client returned to the court for action.

Findings: Based on the above policy and interviews, the facility meets this standard.

MEDICAL AND MENTAL CARE

Standard 115.282: Access to emergency medical and mental health services

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

115.282 (a)

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

115.282 (b)

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

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

115.282 (c)

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

115.282 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy: Facility policy addresses element (a), (b) & (d) above. During the CAP, element (c) was added to policy.

Interviews and observations: Facility policy does not address element (c) above. (During the CAP, element (c) was added to policy.)

Initial findings: BHRTC does not meet this standard as no documentation indicates what agency would perform SANE/SAFE if needed and no MOUs or attempts at MOUs were provided. No documentation of the facility or agency offering 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.

Corrective actions: (1) Develop and implement an MOU with local medical agency or organization to perform SANE/SAFE and medical treatment as outlined in the standard. Attempts to enter into the agreements, whether accomplished or not, are to be provided to the auditor. (2) Add element (c) of the standard to the policy and to the noted MOU.

Action taken: Policy was updated to reflect victims of sexual abuse would be referred to the University Medical Center for medical services and crisis intervention to include timely information about and access to emergency contraception and STD prophylaxis (element (c).

Final findings: While 115.221 requires evidence of the agency's or facility's attempts to provide SANE/SAFE, this standard does not require the same for emergency medical care, although this would be a better practice. Based on the action above and the auditor's re-evaluation of the standard the facility meets the elements of this standard.

Standard 115.283: 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

115.283 (a)

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

115.283 (b)

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

115.283 (c)

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

115.283 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.) ☒ Yes ☐ No ☐ NA

115.283 (e)

- If pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.) ☒ Yes ☐ No ☐ NA

115.283 (f)

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

115.283 (g)

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

115.283 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy: The original policy provided did not address this standard. During the CAP, the agency/facility provided updated policy to address each element of this standard.

Initial findings: The facility does not meet the elements of this standard as the information provided does not address.

Corrective Actions: The facility/agency needs to provide documentation that they (or through MOU): 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; to 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;

Provide such victims with medical and mental health services consistent with the community level of care.

Offer pregnancy tests to resident victims of sexually abusive vaginal penetration while incarcerated and if pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services.

Offer resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate

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.

Action taken: The agency/facility updated policy to address each element of the standard and the above corrective action. The policy indicates several sources for ongoing medical and mental health evaluation and treatment to include; University Medical Center, Emergence Health Network and Center against Sexual Violence.

Final findings: Based on the actions taken above the agency/facility now meet the elements of this standard.

DATA COLLECTION AND REVIEW

Standard 115.286: Sexual abuse incident reviews

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

115.286 (a)

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

115.286 (b)

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

115.286 (c)

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

115.286 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No

- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No

- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No

- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No

- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.286(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.286 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy: BHRTC PREA policy addresses this well using verbiage from the standard itself.

Interviews and observations: In an interview with the PREA Coordinator, the facility has not had need to conduct an incident review but would follow the elements of the standard as addressed in policy.

Findings: Based on policy and interviews the facility meets this standard. The auditor recommends an incident review team checklist or outline of actions be developed to assist the team leader in completing this task when it does occur.

Standard 115.287: Data collection

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

115.287 (a)

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

115.287 (b)

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

115.287 (c)

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

115.287 (d)

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

115.287 (e)

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

115.287 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy: BHRTC PREA policy addresses the elements of this standard.

Other documentation: None

Interviews and observations: While policy addresses the elements, no annual reports or SSV reports were provided. No evidence of public posting was provided.

Initial findings: The agency/facility does not meet this standard.

Corrective actions: The agency/facility needs to develop, implement and provide to the auditor annual reports for 2017 and 2018 to address each element of this standard. Provide the auditor with documentation verifying this information is publicly posted.

Action taken: No documents were provided to the auditor.

Final findings: As no annual reports were provided during the CAP and no indication of publicly posting annual reports, the facility does not meet the standard as noted in the corrective actions above.

Standard 115.288: Data review for corrective action

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

115.288 (a)

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

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☐ Yes ☒ No

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

115.288 (b)

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

115.288 (c)

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

115.288 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy: Policy provided does not address the elements of this standard.

Initial findings: The facility does not meet the standard as no reports are available as required by 115.287, therefore this standard cannot be addressed.

Corrective actions: The agency/facility needs to develop, implement and provide to the auditor annual reports for 2017 and 2018 to address each element of standard 115.287. Provide the auditor with policy or other documentation verifying the elements of this standard (115.288) are addressed from the information gathered to include a comparison (element b) of the last two years. Show documentation of the annual report being posted publicly (element c).

Action taken: No documents were provided to the auditor.

Final findings: As no annual reports were provided during the CAP and no indication of publicly posting annual reports, the facility does not meet the standard as noted in the corrective actions above.

Standard 115.289: Data storage, publication, and destruction

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

115.289 (a)

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

115.289 (b)

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

115.289 (c)

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

115.289 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy: BHRTC PREA policy addresses each element.

Interviews and observations: While policy addresses, no reports are available, therefore the elements of 115.289 cannot be addresses or reviewed.

Initial findings: The facility does not meet the standard as no reports are available as required by 115.287, therefore this standard cannot be addressed.

Corrective action: See corrective actions for 115.287 and 115.288, then address all elements of this standard.

Final findings: No actions were provided to the auditor to address the standard or the corrective action, therefore the agency/facility do not meet 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 (i)

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

115.401 (m)

- Was the auditor permitted to conduct private interviews with inmates, residents, and detainees? ☒ 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*)

Instructions for Overall Compliance Determination Narrative

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

Initial audit for West Texas BHRTC

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 within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Initial audit for West Texas BHRTC.

AUDITOR CERTIFICATION

I certify that:

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

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

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

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.[1] Auditors are not permitted to submit audit reports that have been scanned.[2] See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

[1] See additional instructions here: https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110 .

[2] See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.

Dave Cotten November 7, 2019

Auditor Signature **Date**