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

☐ **Interim** ☒ **Final**

Date of Report December 22, 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:** November 18 & 19, 2019

Agency Information

Name of Agency: Taylor, Callahan, Coleman Counties CSCD		**Governing Authority or Parent Agency** *(If Applicable)*: Click or tap here to enter text.	
Physical Address: 301 Oak Street		**City, State, Zip:** Abilene, TX 79602	
Mailing Address: same		**City, State, Zip:** Click or tap here to enter text.	
The Agency Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☒ County	☐ State	☐ Federal
Agency Website with PREA Information: taylorcscd.org			

Agency Chief Executive Officer

Name: Michael D. Wolfe	
Email: mwolfe@taylorcscd.org	**Telephone:** 325-674-1247

Agency-Wide PREA Coordinator

Name: Jennifer Cauthen	
Email: jcauthen@taylorcscd.org	**Telephone:** 325-691-7407
PREA Coordinator Reports to: Debbie Rowland	**Number of Compliance Managers who report to the PREA Coordinator:** 1

Facility Information

Name of Facility: Taylor County Substance Abuse Treatment Facility

Physical Address: 1133 S. 27th Street	**City, State, Zip:** Abilene, Texas 79602
Mailing Address (if different from above): Click or tap here to enter text.	**City, State, Zip:** Click or tap here to enter text.

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

Facility Website with PREA Information: taylorcscd.org

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

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

☐ ACA

☐ NCCHC

☐ CALEA

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

☒ N/A

If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe: Click or tap here to enter text.

Facility Director

Name:	Debbie Rowland		
Email:	drowland@taylorcscd.org	**Telephone:**	325.691.7407

Facility PREA Compliance Manager

Name:	Leslie Scarborough		
Email:	lscarborough	**Telephone:**	325.691.7407

Facility Health Service Administrator ☒ N/A

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

Facility Characteristics	
Designated Facility Capacity:	72
Current Population of Facility:	63
Average daily population for the past 12 months:	59.59
Has the facility been over capacity at any point in the past 12 months?	☐ Yes ☒ No
Which population(s) does the facility hold?	☐ Females ☒ Males ☐ Both Females and Males
Age range of population:	17-67
Average length of stay or time under supervision	275 days
Facility security levels/resident custody levels	community
Number of residents admitted to facility during the past 12 months	106
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:	104
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *30 days or more:*	89
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	☐ Yes ☒ No
Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):	☐ Federal Bureau of Prisons ☐ U.S. Marshals Service ☐ U.S. Immigration and Customs Enforcement ☐ Bureau of Indian Affairs ☐ U.S. Military branch ☐ State or Territorial correctional agency ☐ County correctional or detention agency ☐ Judicial district correctional or detention facility ☐ City or municipal correctional or detention facility (e.g. police lockup or city jail) ☐ Private corrections or detention provider ☐ Other - please name or describe: Click or tap here to enter text. ☒ N/A
Number of staff currently employed by the facility who may have contact with residents:	31
Number of staff hired by the facility during the past 12 months who may have contact with residents:	14

Number of contracts in the past 12 months for services with contractors who may have contact with residents:	0
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	0
Number of volunteers who have contact with residents, currently authorized to enter the facility:	18
Physical Plant	
Number of buildings: **Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.**	2
Number of resident housing units: **Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.**	1
Number of single resident cells, rooms, or other enclosures:	0
Number of multiple occupancy cells, rooms, or other enclosures:	10
Number of open bay/dorm housing units:	0
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	☒ Yes ☐ No
Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	☐ Yes ☒ No

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

Investigations	
Criminal Investigations	
Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:	0
When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.	☐ Facility investigators ☐ Agency investigators ☒ An external investigative entity
Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)	☐ Local police department ☒ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☐ Other (please name or describe: Click or tap here to enter text.) ☐ N/A
Administrative Investigations	
Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?	2
When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: Select all that apply	☒ Facility investigators ☐ Agency investigators ☒ An external investigative entity
Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)	☐ Local police department ☒ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☐ Other (please name or describe: Click or tap here to enter text.) ☐ N/A

Audit Findings

Audit Narrative

The 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 Taylor County Substance Abuse Treatment Facility (SATF), a community confinement facility was conducted on November 18 & 19, 2019. The audit was conducted by Dave Cotten, a certified National PREA auditor under contract with PREA Auditors of America. This is SATF's first National PREA Audit. Approximately six weeks prior to the on-site visit, the facility posted notifications of the upcoming audit with the auditor's contact information to allow for residents to contact the auditor prior to the audit. Taylor County SATF provided the auditor with file documentation electronically approximately four 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. This is a single facility agency.

An initial in-brief was held at 8:00 a.m. on 11/18/19 with Facility Director Debbie Rowland, PREA Coordinator/Supervisor Jennifer Cauthen, Program Coordinator/PREA Investigator Brad Davis and PREA Compliance Manager/Floor Operations Supervisor Leslie Scarborough. Staff introduced themselves and provided professional background as did the auditor. The Director provided the auditor with an overview of the Taylor County SATF 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.
Following the tour, the auditor began the interviews and reviews of on-site documents.

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 this facility.

The facility reports it has had no reported incidents of sexual abuse, no criminal or administrative investigations over the last 12 months. The facility also reports no LEP or disabled residents are currently housed at the facility for interview purposes.

On the first day of the audit the facility had fifty-eight (58) residents assigned with three who identified as LBGTI. Sixteen (16) residents were interviewed with fourteen (14) being randomly selected by the auditor from a list of all the offenders by their housing assignment at the facility. Two (2) residents who identified as LBGTI were interviewed.

Twelve (12) staff were interviewed who were randomly selected by the auditor from all shifts. Eleven (11) interviews were conducted with specialized staff including the Agency Director, Facility Director, PREA Coordinator/PCM, a medical professional (on-site nurse), the human resources manager, staff who conduct screening for risk of abuse or victimization, incident review team member, staff responsible for retaliation monitoring, a criminal investigator (from outside agency), and administrative investigator, intake staff and first responders. The auditor also interviewed one contractor and one volunteer. In total, thirteen (13) specialized staff/contractor/volunteer interviews were conducted.

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. All security staff are considered first responders and several randomly selected security staff were interviewed as 1st responders as well.

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 tabletop or exercise drills to provide some exposure to experience.

When the on-site audit was completed, the auditor conducted a short de-brief on November 19th, 2019 with Director Rowland and Supervisor Cauthen. The auditor gave an overview of the audit and thanked the Director and the 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.

The Taylor County Substance Abuse Treatment Facility (SATF) is located in Abilene, Texas. The program is governed by the District Courts serving Taylor, Callahan and Coleman counties as a sanction and alternative to incarceration for eligible offenders as outlined in Texas Code of Criminal Procedure.

The facility is a very small with average population of under 60 residents. Two buildings make up the entire facility with the single housing unit and all offices within one building and a second small building having two classrooms. Housing is made up of 10 multi-resident rooms with a bathroom/shower in each room and two bathroom/showers in the bay. Per policy and practice, residents are not allowed in the classrooms or outside the main building without being under staff escort. This includes an outside recreational area.

The SATF is a 9-month, supportive residential treatment program with a cognitive behavioral approach that provides its residents with substance abuse treatment. The 9-month program provides a minimum of 6 months of in-residence education and counseling followed by a minimum of 3 months in the "Employment Phase" with residents seeking employment and working within the community while residing at the facility. A 12-month aftercare program is provided upon successful completion of the in-residence program.

Residents may only be accepted if physically and mentally capable of completing the program.

Summary of Audit Findings

The summary should include the number and list of standards exceeded, number of standards met, and number and list of standards not met.

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

Standards Exceeded

Number of Standards Exceeded: One (1)
List of Standards Exceeded: 115.217

Standards Met

Number of Standards Met: Forty (40)

Standards Not Met

Number of Standards Not Met: zero (0)
List of Standards Not Met: Click or tap here to enter text.

Corrective Actions: MOUs provided in the pre-audit documentation were all unsigned documents. The auditor requested signed MOUs, which the facility provided immediately upon request. This appears to be merely an oversight by the agency as the MOUs showed signatures, with dates, well before the on-site audit. This originally affected standards; 221, 222, 251, 253, 271, 282 & 283. No further action required.

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.

From the SATF Operations Manual, section Z., PREA:
The Taylor County Community Supervision and Corrections Department (CSCD)/Substance Abuse Treatment Facility (SATF) is committed to providing a safe and healthy environment for residents, staff, visitors, contractors and volunteers. We are committed to protecting residents from sexual abuse and sexual harassment. Sexual abuse and sexual harassment compromise the safety of everyone in our

facility and will not be tolerated. The SATF's policy will serve as a mechanism for complying with the Prison Rape Elimination Act (PREA) and the PREA National Standards. [115.211(a), 115.262]

The SATF has mandated a zero-tolerance policy relating to any sexual misconduct and sexual harassment between staff, volunteers, contractors, and residents or their family members. All staff and volunteers will receive training to understand how to prevent, detect and respond to all allegations of sexual abuse and sexual harassment. All allegations, regardless of the source, of coercive, or consensual sexual misconduct/harassment occurring among residents will be fully investigated, sanctioned (if authority to do so exists), and referred for prosecution if the prohibited conduct violates state criminal laws. When it is learned that a resident is subject to a substantial risk of imminent sexual abuse, immediate action shall be taken to protect the resident. All alleged victims of sexual abuse or harassment will be provided a supportive and protective environment. [115.211 (a), 115.262] The SATF has a designated PREA Coordinator, who is the Facility Supervisor, who is given sufficient time and authority to develop, implement, and oversee facility efforts to comply with the PREA standards.

PREA covers incidents involving staff, residents, 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/residents, volunteers/residents or outside the agency involvement between staff and resident.
2. Resident on Resident Sexual Abuse: Sexual contact between residents without the resident's consent, or in which the resident is unable to consent or refuse.
3. Staff Sexual Misconduct: Any behavior or act of a sexual nature whether it be consensual or non-consensual directed toward a resident 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 documents: Org chart reflecting the PREA Coordinator reporting to the SATF Director, the PREA Compliance Manager and PREA investigator reporting to the PREA Coordinator.
"PREA Coordinators Roles and Responsibilities" training certificates from NIC for both the facility director and PREA Coordinator

In interviewing the PREA Coordinator, she states she has sufficient time to manage all PREA related duties and discusses all issues directly with the facility director. All policy regarding PREA, or that may affect PREA standards, is reviewed by both the coordinator and director. Training is conducted for all staff on a regular basis and is conducted for any new staff, contractors or volunteers. All incoming residents receive immediate information regarding zero tolerance and methods of reporting and further receive PREA education during orientation.

Based on the above evidence to include policy, other documents and interviews the agency/facility meets the elements of this standard. This is a single facility agency.

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 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

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.

Per interviews with the agency director and facility director: The agency does not contract with private agencies or other entities for the confinement of residents.

Based on the above, the agency facility meets this standard.

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

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

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

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

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

115.213 (b)

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

115.213 (c)

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

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

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

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

Auditor Overall Compliance Determination

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

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

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

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.

From the SATF Operations Manual, section BB., PREA:

- Schedules will not be approved unless there is at least one male staff member scheduled to work for the entire 12-hour shift.
- In the event there is only one male staff member scheduled to work and for some reason he cannot complete part or all of his shift, the Supervisor of Operations will be immediately notified and another male staff member will be called into work.
- The facility will have at least two staff members on the premises at all times. In the event there is an issue that would leave only one staff member, the on-call person will be called into cover until there is sufficient coverage.
- A video surveillance system is operated through the facility, with the exception of resident's living quarters, including videotaping capabilities and monitors visible to staff.
- An alarm system is connected to all movable windows.
- The front and back entrances are operated by a buzzer security lock.
- All other outside doors are locked and can only be accessed from the outside with a key.
- All visitors must have a picture ID which is viewed by staff prior to entry past the foyer.
- Metal detectors are located at the front and rear entrances of the facility and are utilized for all residents, visitors, and volunteers.
- Hand held metal detectors are used to verify alarms from the walk-through metal detectors and locate the source of metal activation.
- Every time the residents enter the facility, he will pass through a metal detector.
- Whenever possible, meals are supervised by a floor staff member.
- Office doors are to remain open when a seeing a resident. If the door needs to be closed, a witness must be present.

From the SATF Operations Manual, section Z., PREA:
STAFFING PLAN
A. The facility has developed a staffing plan that provides for expected levels of program supervision and monitoring to ensure the facility is safe and secure. The location of video monitoring systems will be considered when determining adequate levels of staffing. In calculating staffing levels and determining the need for video monitoring, the following factors shall be taken into consideration:
1. The physical layout of each building.
2. The composition of the resident population.

3. the prevalence of substantiated and unsubstantiated incident of sexual abuse.
4. any other relevant factors.

B. The Supervisor of Floor Operations is responsible for reviewing the staffing plan in conjunction with the daily Residential Monitor Schedule. If a staffing pattern falls below the staffing plan due to absence, the Shift Supervisor shall notify the Supervisor of Floor Operations of the deviation. The Supervisor of Floor Operations shall:

1. Immediately work to remedy the staff plan deviation.
2. Immediately notify the Facility Director.
3. Document and describe the deviation along with a thorough justification for the deviation

C. Notify the PREA Coordinator of the deviation within seven calendar days and include a description of any corrective actions that were taken to resolve the deviation. Whenever necessary, but no less frequently than once each year, the PREA team shall assess, determine, and document, using the Staffing Plan Annual Review Form, whether adjustments are needed to:

1. The staffing plan
2. Prevailing staffing patterns
3. The facility's deployment of video monitoring and other monitoring technologies
4. The resources the facility has available to commit to ensure adequate staffing levels

Other documentation provided to support meeting the standard includes the SATF Staffing Plan dated 3/19/19 which address each element of the standard; diagram of the physical plant layout; a memo to file from the director stating the second, portable, building was added in 2011 and cameras were installed as part of that project; and a list of identified blind spots and how the facility addresses know blind spots.

Interviews conducted with the agency head and PREA coordinator indicate the agency and facility consider the physical layout of the facility, the current resident population and other relevant factors in assessing adequate staffing levels and the need for video monitoring. Both indicated they would consider incidents of sexual abuse but have had none to date. Both staff also state the plan is reviewed at least annually with at least the agency head, facility head and PREA coordinator involved in the reviews. Deviations would be reported and documented should that occur; however, the facility has processes in place to prevent the facility from going below a minimum staffing level.

Based on the above evidence, the agency/facility meets the elements of this standard.

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 the facility does not have female residents.) ☐ Yes ☐ No ☒ NA

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

115.215 (c)

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

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

115.215 (d)

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

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

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

115.215 (e)

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

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

115.215 (f)

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

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

Auditor Overall Compliance Determination

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

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

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

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.

From the SATF Operations Manual, section CC., Searches:
All searches will be carried out in a manner as to allow as much respect for the resident's dignity and property as possible.
• Staff will be trained using the CJAD training video on pat downs.
• Female staff members do not conduct pat down searches.
• Male staff will pat down all residents entering the facility who have not been under constant supervision of a staff member.
Strip Search
• Strip searches will be conducted as follows or when staff suspects the need to do so.
o All employment returning from work
o All outside CSR returning from the CSR
o 4 random per day per shift
o Outside groups – 2 random and anyone who has left sight of the staff member/members attending the meeting.
• When possible two male staff members will be present for the strip searches. When two male staff members are not available, one male will follow the search guidelines below with a female staff member standing outside the door, with the door ajar allowing the female staff to hear what is being said between the male staff and resident.
• Female staff members will not participate in the physical strip search or be in view of the physical strip search.
• No body cavity searches are conducted.
• The strip search will be documented in the Daily Log to include time of the search, resident being searched, staff members conducting the search and the reason for the search.

From the SATF Operations Manual, section Z., PREA states no cross-gender strip searches will not be conducted except in exigent circumstances; residents may shower, perform bodily functions, and change clothing without opposite gender staff viewing; female staff will announce themselves before entering area residents are likely to be showering, performing bodily functions or changing clothes; searches or physical examination of a transgender or intersex resident for the sole purpose of determining the resident's genital status is prohibited. If the resident's genital status is unknown, it may be determined 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; and staff shall complete the following training: Cross Gender Supervision and Liability and Cross Gender and Transgender Pat-downs to be informed on how to conduct cross-gender pat-down searches and searches of transgender and intersex residents, in a manner that is professional, respectful and the least intrusive possible while being consistent with security needs.

Other documentation provided to support meeting this standard are; a cross gender viewing & searches log; page from handbook informing residents they must change clothes in the restroom with the door shut; a roster of staff completing the Moss Group's training on conducting professional and respectful cross-gender searches of inmates.

All random residents interviewed stated someone always announces a female entering their rooms and they never felt they could be viewed, in a state of undress or using the shower or toilet, by female staff.

All staff interviewed stated female staff or visitors to the facility are announced prior to entering a resident room. Staff also state residents are never in a position to be viewed, in state of undress, by female staff. Staff state they have had recent training on appropriate cross-gender search training.

Based on the above evidence, the agency/facility meets the elements of this standard.

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

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From the SATF Operations Manual, section Z., PREA:
A. In the event a resident has difficulty understanding provided information or procedures outlined in this policy, employees must ensure that such information is effectively communicated to such residents on an individual basis.
B. Program Coordinator will assign residents to Counselors based on the needs of the resident including those with limited English skills, reading or writing abilities. Documents and PREA video are available in Spanish and in large font and PREA documents are verbally reviewed with all residents.
C. Auxiliary aids that are reasonable, effective, and appropriate to the needs of the resident shall be provided when simple written or oral communication is not effective.
D. Residents will not be relied upon to provide interpretation services, act as readers, or provide other types of communication assistance except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-responder duties, or the investigation of the resident's allegations. Such cases will be documented in the daily log.

Other documents provided to support meeting this standard are: PREA Brochures, policy, posters in English, large print and Spanish; review of website indicating qualifications for the program requires residents to be physically and mentally capable to complete the program.

There were no LEP or disabled residents assigned to the program for interview. Staff interviewed were well aware that residents should not be allowed to interpret for another regarding sexual abuse or harassment except in extreme time sensitive emergencies.

Based on the above evidence provided and reviewed, the agency/facility meet the elements of this standard. Residents must be physically and mentally capable of completing the program prior to acceptance.

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 who may have contact with residents? ☒ Yes ☐ No

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

115.217 (c)

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

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

115.217 (d)

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

115.217 (e)

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

115.217 (f)

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

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

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

115.217 (g)

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

115.217 (h)

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

Auditor Overall Compliance Determination

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

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

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

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.

From the SATF Operations Manual, section Z., PREA:
Any incident of sexual harassment shall be considered in determining whether to hire or promote any individual or to enlist the services of any contractor, who may have contact with residents.
A. To the extent permitted by law, this facility shall not hire or promote and may terminate employment based on material omission regarding such misconduct of anyone and may not enlist the services of any contractor/volunteer who may have:
1. Engaged in sexual abuse in a prison, jail, lock up, community confinement facility, juvenile facility, or another institution.
2. Been convicted of engaging or attempting to engage in any type of sexual misconduct 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.
3. Been civilly or administratively adjudicated to have engaged in any type of sexual misconduct.
B. Before hiring new employees or enlisting the service of any contractor/volunteer that may have contact with residents, the facility shall:
1. Perform a criminal background records check;
2. Make 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 in consistent with federal, state, and local laws.
3. Perform a criminal background records check before enlisting the services of any unescorted contractor who may have contact with the residents.
4. Perform a criminal background check on current employees or contractor who has contact with the residents annually.
5. Ask all applicants and employees about previous sexual misconduct in written applications or interviews for hiring or promotions and impose upon employees a continuing affirmative duty to disclose any such misconduct by completing the Employee Annual PREA Questionnaire at their annual evaluation date.
6. Consider material omissions or the provision of materially false information regarding sexual misconduct grounds for termination.
7. Provide information on substantiated allegations of sexual misconduct involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work, unless prohibited by law.

Other documentation provided to support meeting this standard includes: "Employer Reference" form which would be sent, upon request, to prospective employers of this agency's former employees and includes relative information regarding PREA; Employment application which requires prospective employees to answer the relative questions concerning sexual abuse or harassment; completed and signed Employee annual PREA questionnaire required of every employee annually (staff selected by auditor); excerpt from CSCD personnel policies and procedures manual article 5, hiring which requires the HR department to complete background checks and to make best efforts to contact previous institutional employers; completed and signed applicant PREA questionnaire to be completed and signed by prospective employees; memo from HR dated 10/16/19 stating all staff have had background checks completed; examples of completed annual criminal history searches for random staff selected by the auditor.

In an interview with HR staff, staff stated they do perform criminal record background checks and consider pertinent civil or administrative adjudications for all newly hired employees. All background checks are repeated annually. The facility has no contractors enter the facility without being under staff escort at all times. Any prior incidents are considered prior to hiring or promoting anyone. The agency uses NCIC and DPS for all background checks. HR staff also indicate they ask all applicants about previous misconduct and they sign an acknowledgment to that fact. Staff also sign that acknowledgment annually. HR also has a form to complete for any potential employer of previous agency employees and all employees sign a consent to release form at hire.

Based on the above evidence provided prior to, during and after the on-site audit, the agency/facility exceeds the elements of this standard. Annual staff background checks, annual staff questionnaires on history, employer reference forms, etc... show going beyond meeting 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*)

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

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The SATF Operations Manual, section Z., PREA states:
The facility shall consider the effect of the design, acquisition, expansion, or modification upon the facility's ability to protect residents from sexual abuse when designing or acquiring a new facility or installing or upgrading video monitoring systems.
The operations manual also requires all resident will be escorted or supervised any time outside the building on facility property and residents are not allowed in classrooms unattended.

The facility does note a portable building was added in 2011 for classrooms. Cameras were installed as part of that project with sexual safety of residents and staff a consideration. The facility also provided the auditor with a layout of the facility with camera placement and a list of identified blind spots.

The agency head and facility head both stated any new construction or updates to electronic monitoring equipment planning would always consider the sexual safety of all persons.

Based on the information provided, the agency/facility meets the elements of 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? (N/A if agency *always* makes a victim advocate from a rape crisis center available to victims.) ☒ Yes ☐ No ☐ NA

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

115.221 (e)

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

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

115.221 (f)

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

115.221 (g)

- Auditor is not required to audit this provision.

115.221 (h)

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

Auditor Overall Compliance Determination

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

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

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The SATF Operations Manual, section Z., PREA states:
The investigating entity shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. If the facility is not responsible for investigating such allegations, the facility shall request that the responsible outside agency or entity (i.e., state or local law enforcement, contracting agency, etc.) comply with these requirements.
A. The protocol shall be, as appropriate, adapted from the National Protocol for Sexual Assault Medical Forensic Examinations (www.ncjrs.gov/pdffiles1/ovw/206554.pdf).
B. The investigating entity and/or facility shall offer all victims of sexual abuse access to forensic medical examinations, whether onsite or at an outside facility, without financial cost, where evidentiary or medically appropriate. Such examinations shall be performed by a SAFE or SANE where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The investigating entity shall document its efforts to provide SAFEs or SANEs.
C. The investigating entity and/or facility shall attempt to make available to the victim a victim advocate from a rape crisis center. The investigating entity and/or facility may utilize a rape crisis center that is part of a government unit as long as the center is not part of the criminal justice system (such a law enforcement agency) and offers a comparable level of confidentiality as a non-governmental entity that provides similar victim services.
D. As requested by the victim, either the victim advocate, a qualified investigating entity staff member, or qualified community-based organization staff member shall accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information and referrals.

E. A qualified agency staff member or qualified community-based staff member shall be an individual who has been screened for appropriateness to serve in this role and has received education concerning sexual assault and forensic examination issues in general.

The agency/facility also provided signed MOUs with the Hendrick Medical Center for SANE, Regional Victim Crisis Center for advocates and the Taylor County Sheriff's Office for criminal investigations within the guidelines of PREA standards.
The facility's PAQ, and confirmed in interviews, indicates the facility has had no cases of sexual abuse requiring a SANE, victim advocate or investigation.

Random staff interviewed indicated they were aware to attempt to ensure physical evidence integrity is maintained by securing the crime scene, communicating with the reported victim to encourage not washing his hands, using the toilet, eating or drinking, brushing his teeth, etc.. The staff knew to contact medical and the facility PREA staff and investigators who would notify the SO for criminal investigation.
A representative from the medical center who also conducts SANE stated the medical center would provide SANE to Taylor County SATF victims of sexual abuse. SANE staff are available 24 hours a day, 7 days a week.
An interview with the criminal investigator from the SO confirmed Hendricks Medical Center performs SANE as needed and authorized.
The PREA Coordinator states they do provide a victim advocate as provided for in the MOUs with the Taylor County SO and the Regional Victim Crisis Center.
As there have been no alleged cases of sexual assault requiring SANE, no residents who reported sexual abuse were interviewed.

Based on the above evidence provided, to include signed MOUs and policy and the interviews conducted, the facility meets 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 the policy describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for conducting criminal investigations. See 115.221(a).) ☒ Yes ☐ No ☐ NA

115.222 (d)

- Auditor is not required to audit this provision.

115.222 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

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The SATF Operations Manual, section Z., PREA states:
A. The Facility Director shall ensure that an administrative investigation and a referral to the Taylor County Sheriff's Office for a criminal investigation, where appropriate, are completed for all allegations of sexual abuse and sexual harassment. All referrals are documented and the CSCD Director is kept informed by the Facility Director.
B. This policy along with the MOU with the Taylor County Sheriff's Office will be published on the CSCD website with all other PREA information.

The facility also provided a signed MOU with Taylor County SO requiring the SO to investigate allegations as required by PREA standards.
A review of the Taylor County CSCD website confirms the policy is posted identifying who is responsible for what actions in investigations of sexual abuse/harassment.

The agency head states all cases of sexual abuse would be reported to and investigated by the Sheriff's Office investigative unit. The agency/facility has an MOU with the SO for that purpose. Both the administrative and criminal investigators interviewed stated any allegation is reviewed by the SO who determines if there are potential criminal acts, then referred to the SO. If obviously not criminal, case may be referred to agency administrative investigator.

Based on the above evidence provided, to include the MOU, review of website, policy and the interviews conducted, the facility meets the elements of this 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*)

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

Instructions for Overall Compliance Determination Narrative

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The SATF Operations Manual, section Z., PREA requires:
A. All staff members will be trained on the following tailored to male residents:
1. The zero-tolerance policy on sexual misconduct and sexual harassment.

2. How to fulfill their responsibilities of prevention, detection, reporting, and response to sexual misconduct.
3. Residents' rights to be free from sexual misconduct.
4. The right of residents and employees to be free from retaliation for reporting sexual misconduct.
5. The dynamics of sexual misconduct in confinement.
6. The common reactions of sexual misconduct victims.
7. How to detect and respond to signs of threatened and actual sexual misconduct.
8. How to avoid inappropriate relationships with residents.
9. How to communicate effectively and professionally with residents, including LGBTI and gender non-conforming residents.
10. How to comply with relative laws related to mandatory reporting of sexual misconduct.

B. All current staff members will receive PREA training within one year of hire and refresher training annually thereafter to ensure all employees understand the agency's current sexual misconduct policies and procedures.

C. Employees transferring to a facility that houses a population whose gender is different from their previously assigned facility shall receive additional training specific to the population of the newly assigned facility.

D. Employees shall be required to confirm, by either electronic or manual signature, their understanding of the received training. Signed documentation will be maintained in the employee's training file.

Rosters of staff completed training in cross gender supervision and searches and completed staff training acknowledgements signed by the employee and the trainer were also provided.

Interviews with random staff indicate good knowledge of the subsections of element (a) of this standard. As the facility has not had any incidents, the auditor recommends table top and/or real time drills to allow staff the opportunity to gain some experience in the process of responding to an incident.

Based on the above evidence provided, to include policy, training rosters, signed staff acknowledgement forms and the interviews conducted, the 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

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The SATF Operations Manual, section Z., PREA requires:
A. Volunteers and contractors will be notified of the facility's zero-tolerance policy of sexual abuse as well as their responsibility under the facility's misconduct, and harassment prevention, detection, and reporting and response policies and procedures.
B. The level and type of training provided to volunteers and contractors shall be based on the services provided and the level of contact they have with residents.
- Volunteers with direct contact with residents will:
(a) View the PREA: What You Need to Know education video
(b) Receive the PREA Brochure & a copy of the SATF PREA Policy
(c) Sign the PREA Acknowledgement
- Non-employees who are in the building without direct contact with residents will:
(a) Receive the PREA Brochure
(b) Sign the PREA Acknowledgment

C. Documentation acknowledging understanding of the training they received will be maintained by the facility.

The agency/facility also provided blank and completed/signed volunteer acknowledgement forms; PREA information brochure; an outline of the video training titled "PREA, What You Need to Know;"

Two volunteers were interviewed with both stating they had received training related to sexual abuse and harassment. Both have contact with offenders and did state they were trained on the zero-tolerance policy, what their responsibilities are regarding he sexual abuse or harassment of offenders, maintaining professional boundaries with offenders, hat to report and to whom. Both stated they would report any suspicions directly to security staff, the shift commander, the PREA Coordinator or the Director, depending on the circumstances. They remember the training including a video and brochure and a question/answer session at the conclusion of the training.

Based on the above evidence provided, to include policy, signed volunteer acknowledgement forms for all 15 listed volunteers and the interviews conducted, 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

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The SATF Operations Manual, section Z., PREA requires:
A. During the intake process, all residents, including those transferred from another facility, shall receive information in a manner that is understandable regardless of individual limitations explaining:
1. The agency's zero-tolerance policy regarding sexual abuse and sexual harassment
2. How to report incidents or suspicions of sexual abuse or sexual harassment.
3. Their right to be free from sexual abuse and sexual harassment.
4. Their right to be free from retaliation for reporting such incidents.
5. Agency policies and procedures for responding to such incidents.
6. Consequences of false allegations.

B. Residents will:
1. View the PREA: What You Need to Know education video
2. Be provided the Taylor County SATF PREA Brochure
3. Receive the Resident Rulebook that includes the PREA Policy
4. Complete the Resident PREA Acknowledgement Form which will be maintained in the resident's CSS file.

C. In addition to providing such education, the facility shall ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats.

In addition to policy, the facility provided blank and randomly selected by the auditor, completed/signed resident acknowledgement forms, the PREA Brochure that all incoming residents receive, excerpts

from the resident handbook that all residents receive that includes an extensive PREA Policy statement and PREA Grievance policy and an outline of the Video “PREA, What You Need to Know.”

Intake staff interviewed stated they do provide all incoming residents with zero tolerance information and how to report sexual abuse or harassment. This is completed at intake upon arrival with follow-up completed at orientation within three days. Education is completed in classroom setting with person presentation, a video, brochures and a question/answer period. Resident are advised about their right to not be abused or harassed, their right to not be retaliated against for reporting how and to whom to report and to look for the posters throughout the facility.
The majority of random residents interviewed stated they received education about the facility’s rules against sexual abuse and harassment within the 1st or 2nd day. Some said within the 1st week. They stated the education did address their right to not be sexually abused or harassed, their right to not be punished for reporting and how to report sexual abuse. Most stated the education included a video, a brochure and a handbook containing the information. All stated there were posters throughout the facility addressing PREA and how to report.

The auditor did observe PREA informational posters throughout the facility and did ask residents to see resident handbooks and brochures during the tour. Policy, brochures and posters are available in Spanish and large print as well as English. Per policy, acceptance to the program requires residents to be physically and mentally capable of completing the program.

Based on the above evidence provided, to include policy, signed resident acknowledgement forms, other documents and the interviews conducted, the 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 receive training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).)
  ☒ Yes ☐ No ☐ NA

115.234 (b)

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

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

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

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

115.234 (c)

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

115.234 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

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The SATF Operations Manual, section Z., PREA requires:
In addition to the general training provided to all employees, the facility shall ensure that, to the extent the facility itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings. The facility shall maintain documentation confirming that investigators have completed the required specialized training.

Specialized training shall include techniques for interviewing sexual abuse victim, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral.

The facility also provided training completion certificates titled "PREA: Investigating Sexual Abuse in a Confinement Setting" presented by the NIC for two agency/facility staff administrative investigative staff.

Training records for one criminal investigator (also interviewed) from the SO indicating sexual abuse/harassment investigation training.

A Taylor County Sheriff's Office criminal investigator and one of two agency administrative investigators were interviewed. The criminal investigator stated he has received sex crimes investigation training throughout his long career and did complete the PREA Resource Center's NIC training for PREA related investigations.
The administrative investigator stated he has completed the PREA Resource Center's NIC training for PREA related investigations. Both stated their trainings did cover topics such as; Miranda and Garrity warnings, sexual abuse evidence collection, interviewing sexual abuse victims, and the different levels of evidence required for substantiating a case and possible prosecution.

Based on the above evidence provided, to include policy, training certificates, other documents and the interviews conducted, 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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
  ☒ Yes ☐ No ☐ NA

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

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

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

115.235 (b)

- If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency does not employ medical staff or the medical staff employed by the agency do not conduct forensic exams.)

☐ Yes ☐ No ☒ NA

115.235 (c)

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

115.235 (d)

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

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

Auditor Overall Compliance Determination

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Instructions for Overall Compliance Determination Narrative

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The SATF Operations Manual, section Z., PREA requires:
All full and part-time Qualified Medical and Mental Health Professionals, who work regularly in the facility, shall receive specialized medical training as outlined below:
1. How to detect and assess signs of sexual abuse and sexual harassment.
2. How to preserve physical evidence of sexual abuse.
3. How to respond effectively and professionally to victims of sexual abuse and sexual harassment.
4. How and to whom to report allegations of sexual abuse and sexual harassment.

The facility shall maintain documentation confirming that investigators have completed the required specialized training.

All substance abuse counselors completed the NIC's "PREA: Behavioral Health Care for Sexual Assault in a Confinement Setting" training and the only part time medical staff competed the NIC's "PREA 201 for

Medical and Mental Health Practitioners" training. Certificates were provided to the auditor in file documentation.

Forensic examinations are not conducted at the facility or by agency/facility staff.

Medical staff interviewed stated they had completed specialized training in addition to the mandated agency/facility PREA training. The training covered thing like, evidence collection, how to detect possible sexual abuse in a victim, who and how to report, etc… Staff stated all SANEs would be conducted at the local medical center who have 24/7 SANE availability.

Based on the above evidence provided, to include policy, training certificates, other documents and the interviews conducted, the facility meets the elements of this 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*)

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

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The SATF Operations Manual, section Z., PREA requires that during the first 72 hours of arrival all residents are screened for risk of victimization or abusiveness. A screening form is to be used. The screening tool must consider, at a minimum:
1. Whether the resident has a mental, physical, or developmental disability.
1. The age of the resident.
2. The physical build of the resident.

3. Whether the resident has previously been incarcerated.
4. Whether the resident's criminal history is exclusively non-violent.
5. Whether the resident has prior convictions or sex offense against an adult or child.
6. Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming.
7. Whether the resident had previously experienced sexual victimization.
8. The resident's own perception of vulnerability.
9. Prior sexual acts of abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse as known to the facility.

Policy further requires that all residents will be reassessed with 30 days of arrival and when warranted due to referral, request, incident of sexual abuse or receipt of additional information. Residents may not be disciplined for refusing to answer or for not disclosing information. Only the treatment team has access and will not share information with anyone except the facility director.

The facility uses an objective screening tool addressing all criteria as outlined in element (d) of this standard. The auditor selected, requested and received several initial assessments and subsequent re-assessments. The facility also uses referral forms for residents who suffered prior sexual abuse for referral to counselors and/or medical/mental health or identifies as transgender or intersex and requests to see mental health or counseling staff. The facility reports they were not doing 30 day re-assessments until May or this year (2019). Auditor reviewed assessments and re-assessments dating back to May, therefore the facility meets the requirements of that element.

Staff responsible for risk assessments state all residents are assessed for risk of victimization or abusiveness upon arrival at the facility regardless of where they come from. This normally occurs the day of arrival and prior to housing assignments (occasionally the 2nd day). Staff had good knowledge of all that is considered on the screening instrument and indicate the process incudes a history check, interview with the resident and use of the screening instrument. Residents are given the opportunity to share concerns and ask questions. The status of all residents is reviewed within 30 days of arrival and re-assessments would be completed due to a referral, new information is received, or an incident occurs. Residents would not be disciplined for refusing to disclose information on the form or refusing to answer. Staff state only the Director and he treatment team have access to the specific information on the assessments.
The PREA Coordinator confirmed only the director and the treatment team have access to the specific information covered in the assessments.
The majority of random residents interviewed stated they were asked questions such as had they suffered prior sexual abuse, do they identify as LBGTI, had they ever committed sexual abusiveness, how the felt about their own safety at the facility, etc… Most stated these questions were asked immediately upon arrival.

Based on the above evidence provided, to include policy, completed initial screening instruments and re-assessments, other documents and the interviews conducted, the facility 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? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) ☒ Yes ☐ No ☐ NA

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

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

Auditor Overall Compliance Determination

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

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

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Agency/facility policy requires use of the information from screenings to determine room and bed assignments. Any resident with risk factors being identified are reviewed by the program coordinator/PREA investigator and floor supervisor/PCM to determine placement. Policy requires floor staff and counselors are made aware of high-risk residents and required to monitor for signs of victimization or abusiveness.
Policy requires placement of transgender or intersex residents are on a case-by-case basis with the safety of the residents and the security of the facility in mind. Transgender or intersex resident's own view with respect to his or her own safety shall be given serious considerations, per policy. Policy requires no LBGTI resident may be placed based solely on their status or identification.

The facility uses a code to identify residents at high risk for housing/bed placement and supervision of residents.

The PREA Coordinator explained the process of placement based on the assessment of residents. Incoming residents are assessed and if identified as high risk for victimization or abusiveness, they are coded as such, reviewed by the treatment team and placed appropriately. Monitoring staff are aware of the higher risk, but not the reasons for the higher level. Coordinator also states any transgender or intersex residents would be reviewed by the same team for placement and their views are a consideration. All showers are separate, individual showers. The facility has not dedicated area for placement other than ensuring residents at high risk for victimization are kept separate from residents at high risk for abusiveness.

Staff responsible for risk assessments state the information from the risk screenings is used to determine room and bed assignments individually by the treatment team. All residents' views on their safety are considered including transgender or intersex residents.

Two residents who identify as gay were interviewed with both stating they did not feel they had been placed in a specific room of bed based solely because of their identification status. There were no identified transgender or intersex residents at the facility at the time of the on-site for interview.

Based on the above evidence provided, to include policy, completed initial screening instruments and re-assessments, screen shots of resident profiles with risk coding and the interviews conducted, the facility 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

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The SATF Operations Manual, section Z. states:
Residents who are victims of or have knowledge of sexual misconduct shall be encouraged to immediately report the incident. Residents are not required to submit a written report or go through formals steps to report allegations of sexual abuse or sexual harassment.
Reports can be made:
1. Verbally
2. In writing
3. Anonymously
4. From third parties.

Residents may report sexual misconduct, retaliation by residents or staff for reporting sexual misconduct, and staff neglect or violations of responsibilities that may have contributed to such incidents any of the following ways:
1. Contact the Facility Director, Debbie Rowland, in person or by phone at 325-691-7407.
2. Report to ANY staff, volunteer, or contractor.
3. Submit a grievance, emergency grievance, or staff relate to the locked staff relate box.
4. Contact PREA Coordinator, Jennifer Cauthen, in person or by phone at 325-691-7407.
5. Tell a family member, friend, legal counsel, or anyone else outside the facility who can report on their behalf by calling 325-691-7407.
6. Contact the Regional Victim Crisis Center, anonymously or named, by phone at 325-677-7895.

Employees may privately report sexual abuse and sexual harassment of residents by forwarding a letter, sealed and marked "confidential", to the facility Director. Employees can also make an anonymous report to the Regional Victim Crisis Center at 325-677-7895.
Policy goes on to require staff to accept reports made verbally, in writing, anonymously and from third parties and promptly document any verbal reports.

Also provided in support of meeting this standard is an MOU with the Regional Victim Crisis Center providing for a 24 hour reporting and crisis line available to all residents and all staff. A brochure is provided to all residents with several methods of reporting as noted in the policy above.

Interviews with random staff confirm residents have numerous ways to report including privately through the crisis center. Staff state they must accept and report, made no matter what the source, and must document the receipt of such reports. Staff also knew they could report privately through the crisis line or go directly to the Director or SO.

Of the random residents interviewed, all stated they could report to staff or up the chain of command. Most knew they could report to a family member or could report through the PREA hotline (crisis center). Almost all knew they could report anonymously, verbally, in writing or through a 3rd party.

Based on the above evidence provided, to include policy, MOU, brochure, handbook and the interviews conducted, the facility 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

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

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The SATF Operations Manual, section Z, page 12 provides for each element of this standard with verbiage directly from the standard itself.

The resident handbook, which is given to all residents, also defines the PREA Grievance Policy for resident reference.

Based on the above evidence provided in policy and handbook, the facility meets the elements of this standard. The facility reports no grievances have been filed relating to sexual abuse or harassment.

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

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The SATF Operations Manual, section Z states:
A. The facility shall allow residents access to contact the Regional Victim Crisis Center through their 24-hour hot line at 325-677-7895 or through the mail at Regional Victim Crisis Center, PO Box 122, Abilene, Texas 79604.
B. In unforeseen circumstances where Regional Victim Crisis Center services are not available, the facility shall allow residents access to contact the Betty Hardwick Center through their 24-hour hotline at 800-758-3344 or walk-in assistance Monday – Friday 8:00am – 3:30pm.
C. All communication between the resident and the Regional Victim Crisis Center and/or Betty Hardwick will be done in as confidential manner as possible.
D. Prior to giving them access, the facility shall inform the resident 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 and have them sign the RVCC Support Services Referral Form or the Betty Hardwick Support Services Referral Form.

Also provided in support of meeting this standard was a “Regional Victim Crisis Center (RVCC) Referral for Support Services” form, a “Betty Hardwick Referral for Support Services” form, an MOU with RVCC for victim services and emotional support for victims and a brochure with contact phone numbers and address. The auditor did review posters throughout the facility with RVCC phone numbers and addresses.

Residents interviewed had limited knowledge of outside support services with some stating that there was phone numbers and addresses posted for contact with support services. Most did not know who that was or what was offered. Most did believe communications with such an agency would be confidential unless a crime was reported. There were no residents who had reported sexual abuse assigned to the facility to interview for this standard.

Based on the above evidence provided in policy, referral forms, MOU with the Regional Victim Crisis Center and interviews conducted the facility meets 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

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Policy states:
Third party reporting is accepted and may be done by:
1. Contacting the Facility Director, Debbie Rowland, in person or by phone at 325-691-7407.
2. Contacting PREA Coordinator, Jennifer Cauthen, in person or by phone at 325-691-7407.
3. Contact the Regional Victim Crisis Center, anonymously or named, by phone at 325-677-7895.
4. Submitting a written report that may sealed and marked “confidential” if so desired

A. In person to the Facility Director
B. Mailed to 1133 S. 27th Abilene, Texas 79602 ATTN: Facility Director
C. Mailed to RVCC, PO Box 122, Abilene, Texas 79604 ATTN: Taylor County SATF Facility Director

A review of the website, http://taylorcscd.org/satf.htm, indicates 3rd parties may report via the PREA Coordinator and gives the phone number.

Based on the above evidence provided in policy and the website the facility 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*)

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The SATF Operations Manual, section Z states:
A. Regardless of its source, staff members shall immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment by notifying the PREA Coordinator, [redacted], and their immediate supervisor. The PREA Coordinator or immediate supervisor shall immediately forward all reports to the Facility Director.
1. Staff will be required to submit, to the Facility Director, a detailed summary statement of all reports as soon as possible but not later than the end of the following business day.
B. Regardless of its source, staff members shall immediately report any knowledge of retaliation against a resident or staff who reported such an incident by notifying the PREA Coordinator Jennifer Cauthen, and their immediate supervisor. The PREA Coordinator or immediate supervisor shall immediately report all reports to the Facility Director.

1. Staff will be required to submit, to the Facility Director, a detailed summary statement of all reports as soon as possible but not later than the end of the following business day.

C. Staff members shall immediately report any employee's neglect or violation of responsibilities that may have contributed to an incident or retaliation by notifying the PREA Coordinator, Jennifer Cauthen, and their immediate supervisor.

D. Apart from reporting to the PREA Coordinator, immediate supervisor, and/or Facility Director, employees shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary, and as specified in this policy, to make treatment, investigation, and other security and management decisions.

E. Employees shall not share information related to PREA incidents with uninvolved parties. Employees shall not seek or use information related to PREA incidents beyond that needed to perform professional responsibilities.

F. Unless otherwise precluded by federal, state, or local law, medical and mental health professionals shall be required to report sexual abuse or sexual harassment as stated for all staff in (A), (B), and (C) of this section and shall inform residents of her/his duty to report, and the limitations of confidentiality, at the initiation of services.

G. If the alleged victim is under the age of 18, the facility shall report the allegation to Child Protective Services @ 325-691-8100.

H. The facility shall report all allegations of sexual abuse and sexual harassment, including third party and anonymous reports, to the Taylor County Sheriff's Department CID @ 325-674-1334.

I. The facility Director shall inform the CSCD Director of all reports.

Interviews with random staff indicate staff know they are required to report any knowledge, suspicion or information regarding incidents of sexual abuse or harassment or; retaliation against residents or staff who reported or; any staff neglect or violation responsibilities that may have contributed to an incident. Staff were also aware no to discuss the allegations with anyone except as necessary for the investigation.

Medical and mental health staff stated they are mandatory reporters of criminal acts and would inform residents of the limits of their confidentiality.

The Director and PREA Coordinator stated any allegations involving a person under the age of 18 or considered a vulnerable adult under Texas State Law would be reported to the Department of Child Protective Services as well as local law enforcement.

Based on the above evidence provided in 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

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Policy states the alleged perpetrator will be located in a safe location as identified in policy and monitored by staff. Movement may include an overnight stay and meals will be provided to the resident. All movement of the resident will be monitored, tracked and documented.

In interviews: The Agency Head states the resident would be removed from the threat, may be moved and investigation would be initiated.
The Facility Head states resident would be separated and isolated pending removal. Movement may occur. Provide protection and emotional support.
Random staff state the initial response to such an incident would be to separate and protect the resident and report up the chain of command.

Based on the above evidence provided in policy and interviews conducted 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

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Policy states:
A. When receiving an allegation that a resident was sexually abused while confined at another facility, the Taylor SATF Director shall notify the appropriate official of the agency where the alleged abuse occurred.
B. Such notification shall be done as soon as possible, but no later than 72 hours after receiving the allegation.
C. If the facility where the alleged abuse occurred is aware of and has investigated the allegation, the Taylor County SATF Director shall document the allegation, name and title of the person contacted, noting that the allegation has already been addressed. Under this circumstance, nothing further need occur.
D. If the allegation was not reported or investigated, a copy of the statement from the alleged victim resident shall be forwarded to the appropriate official at the location where the incident was reported to have occurred. The Taylor County SATF Director shall document the allegation, any details learned from contact with the facility where the alleged abuse occurred, and their response to the allegation.
E. The SATF Director shall ensure that such notifications are investigated in accordance with PREA policy standards if/when such a notification is received.

The Agency Head states the point of contact in such a case is the Facility Director who would report to investigative staff immediately. Agency Head would be notified.
The Facility Head states they have had no such incidents but would investigate as any allegation, interview persons involved, make everyone safe and keep other facility/agency informed.

Based on the above evidence provided in policy and interviews conducted the facility meets the elements of 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

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

The SATF Operations Manual, section Z, with verbiage directly from the standard, requires staff to address each element of paragraph (a) of this standard. This includes separating the alleged victim and abuser, protecting the crime scene, protecting evidence on the persons, reporting, referral to medical, etc….

Also available to staff is the PREA First Responder Checklist for staff which addresses each element of paragraph (a) of this standard, the 1st responder victim question checklist and the quick reference guide for 1st responders in the office PREA binder.

The facility reports there have been no incidents reported that would involve first responder actions. All first responders are security staff and all security staff are 1st responders. Therefore all random security staff were questioned on 1st responder duties as well.

Random staff interviewed (and those interviewed as 1st responders) were well aware of the need to separate the alleged victim and abuser, secure the scene and the evidence within the scene, request the alleged victim not do anything to compromise potential evidence, secure the alleged abuser to protect potential evidence, report up the chain of command, report to medical to ensure treatment and evaluation as necessary to include SANE as appropriate, etc…

Based on the above evidence provided in policy, checklists and interviews conducted the facility meets the elements of this standard. The auditor does recommend the facility consider conducting table-top or real-time exercises as the facility staff have had no experience in responding to a sexual abuse case. Drills or exercises would provide exposure to the actions needed in practice.

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.

The SATF Operations Manual, section Z requires completion of the "PREA Coordinated Response Checklist" to ensure all parties involved meet all of the standards when responding to a sexual abuse incident.

The facility uses the above listed checklist which includes actions of first responders, shift supervisors, medical, PREA Coordinator and PREA Team. The PREA Incident Classification Form outlines when an incident investigation was completed and by whom, the determination of type of abuse or harassment, the findings, etc... The PREA binders outlines the use of the response checklist for use in the incident review process.

The facility head states the facility does have a coordinated response plan which is available in the PREA binders in both floor monitor staff offices as well as the front office central hallway cabinet.

Based on the above evidence provided in policy, checklists and interviews conducted the facility meets the elements of this standard. The auditor does recommend the facility consider conducting table-top or real-time exercises as the facility staff have had no experience in responding to a sexual abuse case. Drills or exercises would provide exposure to the actions needed in practice.

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

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The agency/facility policy addresses this standard with verbiage directly from the standard.

The Agency Head states they have no collective bargaining or any other agreement that limits the ability to remove alleged staff abusers from contact with residents pending an investigation.

Based on the policy and the interview with the Agency Director, the agency/facility meet the elements of this standard. Staff may be removed from contact with residents pending an investigation of alleged sexual abuse or harassment.

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.

The SATF Operations Manual, section Z requires compliance by stating:
A. Retaliation against residents, employees, or other parties for reporting sexual misconduct will not be tolerated. Those who are found to retaliate shall face disciplinary action up to and including unsuccessful discharge for residents and termination for employees. Protective measures by the facility include but are not limited to the following:
1. Periodic status checks for residents
2. Room changes or transfer for resident victims or abusers
3. Removal of alleged staff or alleged resident abusers from contact with the alleged victim
4. Provision of emotional support services for residents or staff who fear retaliation for reporting sexual abuse or for cooperating with investigations

B. For at least 90 days following the report of sexual abuse, the conduct and treatment of residents or staff who reported the sexual abuse and 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 and shall promptly act to remedy the retaliation. The monitoring should include but not be limited to:
1. Resident disciplinary reports
2. Room changes
3. Program changes
4. Negative performance reviews of staff
5. Reassignment of staff

C. If any individual who reports sexual misconduct who expresses a report of or fear of retaliation, the facility shall monitor using the PREA Retaliation Monitoring Report form to monitor and protect that individual against retaliation.
D. If any other individual who cooperates with an investigation expresses a fear of retaliation, the facility shall monitor using the PREA Retaliation Monitoring Report form to protect that individual against retaliation.
E. The PREA Coordinator and/or Facility Director will assign specific staff who will monitor the resident/residents against retaliation. Assigned staff will:
1. Complete the report and report findings weekly to the PREA Coordinator and/or the Facility Director.
2. PREA Coordinator and/or the Facility Director will discuss the findings.
3. The PREA Coordinator and/or the Facility Director will take active or preventive measures deemed necessary to address any retaliatory issues or potential retaliatory issues.

F. The PREA Retaliation Monitoring Report form will be used for this process.
G. The obligation to monitor shall terminate if the allegation is determined to be unfounded.

Also provided to support meeting this standard is the "PREA Retaliation Monitoring Report" which addresses the elements of monitoring for retaliation to include weekly checks of resident disciplinary reports, housing changes, program changes and for residents or staff weekly review of performance evaluations and staff reassignments. Checklist also requires weekly face-to-face contact.

The Agency Head and Facility Head state they may use movement, transfer, removal of staff or resident abusers, emotional support services etc…, to ensure no retaliation occurs. The monitor is designated by the Facility Head should the need occur.
One staff interviewed, as a retaliation monitor, stated retaliation monitoring would begin upon receipt of an allegation and would continue for a least 90 days or the person leaves the facility. Monitoring would cover the alleged victim, and anyone involved in the investigation. Monitor would watch for incident reports, housing changes, program or job changes, etc.., to ensure no retaliation is occurring. Staff would be monitored for performance reports, job changes, poor treatment, etc… Monitor makes initial contact and weekly face-to-face contact. Any indication of retaliation is reported directly to the facility head and PREA coordinator for action.

Based on the above evidence provided in policy, checklists and interviews conducted the facility meets the 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

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The SATF Operations Manual, section Z requires compliance by stating:
A. All investigations into allegations will be done so promptly, thoroughly, and objectively regardless of the reporting party.
B. The Taylor County Sheriff's Office CID will conduct investigations of all incidents of sexual abuse and sexual harassment whose staff is trained in sexual abuse investigations.
C. Their investigators shall:
1. Gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data.

2. Interview alleged victims, suspected perpetrators, and witnesses.
3. Review all prior complaints and reports of sexual abuse involving the suspected perpetrator.
D. When the quality of evidence appears to support criminal prosecution, the facility/investigating agency shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution.
E. The credibility of an alleged victim, suspect, or witness, shall be assessed on an individual basis and shall not be determined by the person's status as resident or staff.
F. The facility/investigating agency shall not require a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation.
G. The investigation shall be documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence. Where feasible documentary evidence should be attached.
H. Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution.
I. The departure of the alleged abuser or victim from the employment or control of the facility shall not provide a basis for terminating an investigation.
J. When outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation.
K. Whenever feasible, the facility 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 facility and the investigating entity in performing sexual abuse investigations.

ADMINISTRATIVE
A. Shall include an effort to determine whether staff actions or failures to act contributed to the abuse.
B. Shall be documented in written reports that include the description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings.
C. These reports, in both criminal and administrative investigations, the facility shall retain all written reports for as long as the alleged abuser is a resident or employee of the facility, plus five years.

The facility also provided training certificates for Agency/Facility administrative investigators and the Taylor County SO criminal investigator's training history (in file 115.234) and the current signed MOU with Taylor County SO.

In an interview with one of the two assigned administrative investigators, he stated all investigations would be initiated by the SO who would determine the level of activity to determine administrative investigation through the SO, administrative investigation referred to the facility (resident on resident harassment cases only) or criminal investigation by the SO. He stated he has received the PREA Resource Center supported NIC "Investigative training in Confinement Settings." He further states the SO would be responsible for evidence collection in sexual abuse cases and would involve statements, medial evals, SANE evidence, trace evidence, crime scene evidence such as bedding, clothing, photos, video, phone records, etc.… Only the SO can recommend referral to the DA for prosecution. In administrative investigations, we would include attempts to determine is staff actions or lack of action may have contributed to the act. All investigations would be well documented and include all related reports, documentation, etc… and would be maintained for at least five years after the person leaves the facility. Investigation are never stopped because the alleged victim or abuser departs the facility.

In interviewing the criminal investigator from the Taylor County SO, he states all allegations are referred first to the SO who determines who is to investigate based on level of act. All criminal cases are investigated by the SO. He states he has had numerous sex crime trainings including the PREA Resource supported NIC training. Evidence collected includes physical evidence such as clothing, bedding, etc…, trace evidence from the clothing, body, etc…, witness statements, documented history, photo evidence, video, etc… All cases having any indication of criminal acts are referred to the DA who determines charges or not. Only the DA can authorize compelled interviews. All statements are considered creditable until proven otherwise. No one can be required to submit to a polygraph, and we would never do that as a condition of continuing and investigation.

Investigative staff, the facility head and PREA coordinator all state the facility and the SO have a good working relationship and would communicate about on-going investigations on a regular basis.

Based on good policy and very good knowledge of the investigators interviewed, the facility meets the elements of this standard. The facility reports no cases have been referred for administrative or criminal investigation.

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

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Policy states:
In any sexual abuse or sexual harassment investigation in which the facility is the primary investigating entity, the facility shall utilize a preponderance of the evidence standard for determining whether sexual abuse or sexual harassment has taken place.

Policy also includes the following definition: Preponderance of the Evidence
n. the greater weight of the evidence required in a civil (non-criminal) lawsuit for the trier of fact (jury or judge without a jury) to decide in favor of one side or the other. This preponderance is based on the more convincing evidence and its probable truth or accuracy, and not on the amount of evidence. Thus, one clearly knowledgeable witness may provide a preponderance of evidence over a dozen witnesses with hazy testimony, or a signed agreement with definite terms may outweigh opinions or speculation about what the parties intended. Preponderance of the evidence is required in a civil case and is contrasted with "beyond a reasonable doubt," which is the more severe test of evidence required to convict in a criminal trial. No matter what the definition stated in various legal opinions, the meaning is somewhat subjective.

Dictionary.law.com

Investigative staff interviewed were aware of the level of evidence (preponderance) required to substantiate a case.

Based on policy and knowledge of the investigators interviewed, the facility meets the elements of this standard. The facility reports no cases have been referred for administrative or criminal investigation.

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 the agency's facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) ☒ Yes ☐ No ☐ NA

115.273 (c)

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

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

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

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

115.273 (d)

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

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

115.273 (e)

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

115.273 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

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.

The SATF Operations Manual, section Z requires compliance by stating:
A. Following an investigation into a resident's allegation of sexual abuse suffered in a facility, the facility shall be informing the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded.
B. If the facility did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the resident.
C. Following a resident's allegation that a staff member has committed sexual misconduct against the resident, the facility shall subsequently inform the resident (unless the agency has determined that the allegation is unfounded) whenever:
1. The staff member is no longer posted within the resident's area;
2. The staff member is no longer employed at the facility; and/or
3. The facility learns that the staff member has been indicted or convicted of a charge related to sexual misconduct within the facility.
D. Following a resident's allegation that he or she has been involved in an incident of sexual abuse by another resident, the facility shall subsequently inform the alleged victim whenever it learns:
1. That the alleged abuser, if a resident, has been indicted or convicted on a charge related to sexual abuse within the facility.
2. That the alleged abuser, if a staff member, is no longer employed by the facility and if he/she has been indicted or convicted on a charge related to the sexual abuse within the facility.
E. All such notifications will be made using the Resident Allegation Status Notification Form.
F. All such notifications or attempted notifications shall be documented. The resident shall sign the forms, verifying that such notification has been received. The signed forms shall be kept in the resident's file in CSS.
G. The facility obligation to report under this standard shall terminate if the resident is released from their care and custody.

The facility provided a PREA Resident Allegation Status Notification for which addresses element (a) – (d) of the standard.

In interviewing the facility head and investigative staff, they would do this if and when an allegation is received and investigated. It is in a form that requires acknowledgment signature. The facility has had no incidents at this time.

Based on policy, acknowledgement form and knowledge of staff interviewed, the facility meets the elements of this standard. The facility reports no cases have been referred for administrative or criminal investigation therefore no notices have been completed.

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

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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 states:
A. Employees shall be subject to disciplinary sanctions up to and including termination for violating facility sexual abuse or sexual harassment policies. Termination shall be the presumptive disciplinary sanction for employees who have engaged in sexual abuse.
B. Disciplinary sanctions for violations of facility 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.
C. All terminations for violations of the facility 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 and to any relevant licensing bodies, unless the activity was clearly not criminal.

-and-

Failure to Report Sexual Misconduct
Employees have the duty to disclose any sexual misconduct, including, but not limited to: A) the employee has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution, or B) the employee 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, or C) the employee has been civilly or
administratively adjudicated to have engaged in the activities as described in (B). Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

Exert from Community Supervision and Corrections Department, Taylor, Callahan, and Coleman Counties Personnel Policies and Procedures Manual Article 3: Rule of Conduct #38

Based on policy the facility meets the elements of this standard. The facility reports no cases involving staff have been referred for administrative or criminal investigation.

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

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The SATF Operations Manual, section Z requires compliance by stating:
A. Any civilian or contractor who engages in sexual abuse shall be prohibited from contact with residents and shall be reported to law enforcement agencies and to any relevant licensing body, unless the activity was clearly not criminal.
B. Any other violation of the facility sexual abuse or sexual harassment policies by a civilian or contractor will result in further prohibitions up to and including termination.

The facility head states volunteers would be removed from the facility and barred access pending investigation. If any indication of wrong doing, the volunteer would be barred permanently from facility access.

Based on policy and the interview with the facility head, the facility meets the elements of this standard. The facility reports no cases involving volunteers or contractors have been referred for administrative or criminal investigation.

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)

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

Auditor Overall Compliance Determination

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

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

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

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 states residents may not "Act out sexually in any way." -and- All residents found guilty of sexual abuse shall be institutionally disciplined in accordance with the facility disciplinary procedures.
A. Sanctions shall be 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.
B. The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his/her behavior when determining what type of sanction, if any, should be imposed.
C. If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility shall consider whether to require the alleged perpetrator to participate in such interventions as a condition of access to programming or other benefits.
D. A resident may be disciplined for sexual conduct with an employee only upon finding that the employee did not consent to such contact.
E. A report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation, therefore, the reporting party should not be disciplined.
F. Sexual activity of any kind between residents is prohibited and they will be discipline for such activity. However, if it is determined that the activity was not coerced, the activity will not be considered sexual abuse.
G. Once the investigation is complete, the victim/alleged victim and the perpetrator/alleged perpetrator are kept separate while housed at the facility or until any recommended transfer or removal is completed.

The facility head indicates all residents found to have violated any sexual abuse or harassment would be terminated from the program and referred back to the sentencing district. Mental disabilities or illness would be a consideration but would not be cause to keep the resident in the program. Medical staff indicate they do not offer therapy or counseling designed to address and correct motivations for abuse as the abuser would not stay at the facility.

Based on policy and the interview with the facility head, the facility meets the elements of this standard. The facility reports no cases of abuse have been referred for administrative or criminal investigation.

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 requires:
A. Resident victims of sexual abuse shall receive timely, unimpeded, and ongoing access to emergency medical treatment at Hendrick Medical Center and crisis intervention services as recommended by medical and mental health practitioners according to their professional judgment. Such referrals will be documented.
B. If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, staff shall take preliminary steps to protect the victim pursuant to 115.262 and shall immediately notify the PREA Coordinator and Facility Director who will make appropriate referrals and document them.
C. Resident victims of sexual abuse shall be 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.
Treatment services shall be 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

Also provided to support meeting this standard is an MOU with Hendrick Medical Center (HMC). The MOU states HMC will provide emergency medical services to any resident of Taylor county SATF who is a victim of sexual abuse. MHC will also provide timely, unimpeded, and ongoing access to emergency medical treatment and crisis intervention. They will provide information and timely access to STI prophylaxis as needed an appropriate. Services will be without cost to the victim regardless of whether the victim names the abuser or cooperates with the investigation.

Medical staff stated, in interview, that resident victims of sexual abuse would receive timely and unimpeded access to emergency medical care and crisis intervention at HMC as outlined in the MOU. Treatment would be based on the hospital doctors and medical staff professional judgement.
First responder staff indicate medical is contacted immediately or, if not available and the situation requires immediate medical care, staff would transport, or the ambulance would be called to transport to the HMC emergency room.

Based on policy and the interview with medical staff and first responders, the facility meets the elements of this standard. The facility reports no cases of sexual abuse have been referred for emergent medical care.

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. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☐ Yes ☐ No ☒ NA

115.283 (e)

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

115.283 (f)

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

115.283 (g)

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

115.283 (h)

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

Auditor Overall Compliance Determination

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

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

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

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.

The SATF Operations Manual, section Z requires compliance by stating:
A. The evaluation and treatment of sexual abuse victims shall include, as appropriate, follow-up services, treatment plans, and whenever necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody.
B. The facility shall provide such victims with medical and mental health services consistent with the community level of care.
C. Resident victims of sexual abuse while at the facility shall be offered tests for sexually transmitted infections as medically appropriate.
D. Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out the incident.
E. Upon learning a resident has a history of resident-on-resident abuse, the counselor will refer the resident to the Program Coordinator who will refer them to Betty Hardwick Center for a mental health evaluation who will also offer treatment when deemed appropriate. This will be done within 60 days of learning of such abuse history.

The MOU noted in standard 15.282 requires Hendrick Medical Center to include follow-up services, treatment plan, and referrals for continued care as appropriated.

Medical staff, in interview state residents are referred to HMC who, per MOU provide follow-up services, treatment plan, and referrals for continued care as appropriated and services provided there are consistent with the community level of care as that is where the community members would go as well. She also states an abuser would be referred to HMC for treatment, but any known resident-on-resident abuser would not complete the program at the facility and would be removed.

Based on policy and the interview with medical staff, the facility meets 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.

The SATF Operations Manual, section Z states:
A. The facility PREA Team shall conduct a sexual abuse incident review within 30 of the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined unfounded.
B. The PREA review team consists of the Supervisor, Supervisor of Operations, and Program Coordinator, with input from line supervisors, investigators, and medical and mental health practitioners.
C. The review team shall:
1. Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect or respond to sexual abuse.
2. Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; LGBTI and/or Gender Non-Conforming identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility.
3. Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse.
4. Assess the adequacy of staffing levels in that area during different shifts.
5. Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff.
6. Prepares a report of its findings using the PREA Incident Review Form and any recommendations for improvement to Facility Director.
7. The facility shall implement the PREA review team's recommendations for improvement or shall document reasons for not doing so.

The facility would use the "PREA Incident Review Form" which is patterned after the elements of the standard addressing each issue and signed by the team members and the Facility Director. The faciliyt reports there have been no incidents at the facility which resulted in an incident review.

The Director states the facility would have an incident review team and would follow the identified checklist should the need occur. The checklist addresses each element of the standard and assigned staff would be within the guidelines of the standard.
The PREA Coordinator and an incident review team member were interviewed, and both confirmed the elements of the standard are on the checklist which would be followed as required. The competed review would be reviewed by the PREA Coordinator and Director with recommendations as appropriate.

Based on policy, the PREA Incident Review Form and the interview with staff, the facility meets the elements of this standard.

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 addresses this standard with verbiage from the standard and is the statistical information would be provided in the annual reports and would use the data to assess and improve the effectiveness of its sexual abuse prevention, detection and response policies, practices and training. The facility reports no incidents have occurred requiring incident reports, investigations or incident reviews.

Based on policy, the facility meets the elements of this standard.

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 addresses this standard with verbiage from the standard and is the statistical information would be provided in the annual reports and would use the data to assess and improve the effectiveness of its sexual abuse prevention, detection and response policies, practices and training. The facility reports no incidents have occurred requiring incident reports, investigations or incident reviews.

The Agency Head states the agency would use collected data to address problem areas, staffing, policy changes, training, etc…, as appropriate to address more effective prevention, detection and response to sexual abuse/harassment. He states he does review and approve the annual report. The PREA Coordinator confirms the agency/facility would review collected data which would be summarized in the annual report. At this point they have not needed to redact any information, but personal identifying information or security concerns would be redacted.

Based on policy and the annual report as viewed on the website, the facility meets the elements of this standard. No comparison is available as 2018 is the first year the agency/facility has produced an annual report and there has been no incident-based data due to no reported incidents. The facility did review and note changes to policy and procedure from 2017 to better address sexual safety of residents.

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*)

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

Instructions for Overall Compliance Determination Narrative

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The SATF Operations Manual, section Z states:
A. The facility shall ensure that data collected pursuant to 115.287 is securely maintained.
1. All documentation from each individual investigation will be maintained in the Facility Director's office in the file cabinet marked PREA. Outside of business hours, the office will remain locked but the file cabinet will remain unlocked allowing the CSCD Director and/or PREA Team access.

B. The facility shall make all aggregated sexual abuse data readily available to the public at least annually through its website. But before making the data public, the facility shall remove all personal identifiers.
C. The facility shall maintain sexual abuse collected data for at least 10 years from the date of the initial collection unless Federal, State, or local law requires otherwise.

The PREA Coordinator states all incident reports and investigative files or other confidential documentation will be maintained in the Director's office in a locked cabinet. The annual report has been posted to the website for public availability.

Based on policy, an interview with PREA Coordinator and the annual report as viewed on the website, the facility meets the elements of 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 residents? ☒ Yes ☐ No

115.401 (n)

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

Auditor Overall Compliance Determination

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

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.

This is Taylor County SATF's initial audit.

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

Auditor Overall Compliance Determination

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

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.

This is Taylor County SATF's initial audit.

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.

Dave Cotten December 22, 2019

Auditor Signature **Date**

[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.