

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

Interim       Final

**Date of Report    November 12, 2019**

## Auditor Information

Name: Dave Cotten	Email: dave@preaauditing.com
Company Name: PREA Auditors of America	
Mailing Address: 14506 Lakeside View Way	City, State, Zip: Cypress TX 77429
Telephone: 713-818-9098	Date of Facility Visit: March 13 & 14, 2019

## Agency Information

Name of Agency: Bexar County Community Supervision and Corrections Department	Governing Authority or Parent Agency (If Applicable): Click or tap here to enter text.
Physical Address: 1876 S207 North Comal. Sheridan Ave.	City, State, Zip: San Antonio TX 78207
Mailing Address: Click or tap here to enter text.	City, State, Zip: Click or tap here to enter text.
Telephone: 210-335-7200	Is Agency accredited by any organization? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
The Agency Is:	<input type="checkbox"/> Military <input type="checkbox"/> Private for Profit <input checked="" type="checkbox"/> Private not for Profit <input type="checkbox"/> Municipal <input type="checkbox"/> County <input checked="" type="checkbox"/> State <input type="checkbox"/> Federal
<b>Agency mission:</b> The mission of the Bexar County Community Supervision and Corrections Department is to empower our staff, Bexar County Criminal Justice System, and community through sentencing options that will effectively utilize resources equipping offenders with optimal foundations to change their lives while assisting with providing a safer community.	
<b>Agency Website with PREA Information:</b> <a href="https://www.bexar.org/2969/Prison-Rape-Elimination-Act-PREA">https://www.bexar.org/2969/Prison-Rape-Elimination-Act-PREA</a>	

## Agency Chief Executive Officer

Name: Jarvis Anderson	Title: Chief Probation Officer
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<b>Email:</b> Jarvis.Anderson@bexar.org	<b>Telephone:</b> 210-335-7320
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**Agency-Wide PREA Coordinator**

<b>Name:</b> Mark S. Herrera	<b>Title:</b> MIOF Director
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<b>Email:</b> Mark.Herrera2@bexar.org	<b>Telephone:</b> 210-631-0303
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<b>PREA Coordinator Reports to:</b> Assistant Chief Rita Garcia	<b>Number of Compliance Managers who report to the PREA Coordinator</b> 0
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**Facility Information**

<b>Name of Facility:</b> Applewhite Recovery Center, Mentally Impaired Offender Facility (MIOF)
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<b>Physical Address:</b> 10975 Applewhite Road, San Antonio TX 78224
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<b>Mailing Address (if different than above):</b> Click or tap here to enter text.
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<b>Telephone Number:</b> 210-631-0270
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<b>The Facility Is:</b>	<input type="checkbox"/> Military	<input type="checkbox"/> Private for Profit	<input checked="" type="checkbox"/> Private not for Profit
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<input type="checkbox"/> Municipal	<input type="checkbox"/> County	<input checked="" type="checkbox"/> State	<input type="checkbox"/> Federal
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<b>Facility Type:</b>	<input type="checkbox"/> Community treatment center	<input type="checkbox"/> Halfway house	<input type="checkbox"/> Restitution center
	<input type="checkbox"/> Mental health facility	<input type="checkbox"/> Alcohol or drug rehabilitation center	
	<input checked="" type="checkbox"/> Other community correctional facility		

**Facility Mission:** Our mission will be achieved through the rehabilitation and social reintegration of the offender by utilizing community-based sanctions and/or services at all times through the partnerships with professional resources and services within our community.

<b>Facility Website with PREA Information:</b> <a href="https://www.bexar.org/2969/Prison-Rape-Elimination-Act-PREA">https://www.bexar.org/2969/Prison-Rape-Elimination-Act-PREA</a>
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<b>Have there been any internal or external audits of and/or accreditations by any other organization?</b>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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**Director**

<b>Name:</b> Rita Garcia	<b>Title:</b> Assistant Chief of Regional Services
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<b>Email:</b> Rita.Garcia@Bexar.org	<b>Telephone:</b> 210-631-0273
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**Facility PREA Compliance Manager**

<b>Name:</b> Click or tap here to enter text.	<b>Title:</b> Click or tap here to enter text.
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<b>Email:</b> Click or tap here to enter text.	<b>Telephone:</b> Click or tap here to enter text.
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## Facility Health Service Administrator

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

**Title:** Click or tap here to enter text.

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

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

## Facility Characteristics

**Designated Facility Capacity:** 300

**Current Population of Facility:** 217

**Number of residents admitted to facility during the past 12 months** 2625

**Number of residents admitted to facility during the past 12 months who were transferred from a different community confinement facility:** 0

**Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 30 days or more:** 2625

**Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:** 2625

**Number of residents on date of audit who were admitted to facility prior to August 20, 2012:** 0

**Age Range of Population:**

Adults

Juveniles

Youthful residents

18 +

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**Average length of stay or time under supervision:** 120-180 days

**Facility Security Level:** minimum

**Resident Custody Levels:** minimum

**Number of staff currently employed by the facility who may have contact with residents:** 93

**Number of staff hired by the facility during the past 12 months who may have contact with residents:** 29

**Number of contracts in the past 12 months for services with contractors who may have contact with residents:** 1

## Physical Plant

**Number of Buildings:** Four

**Number of Single Cell Housing Units:** 0

**Number of Multiple Occupancy Cell Housing Units:** 6

**Number of Open Bay/Dorm Housing Units:** 6

**Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.):** From camera map provided, the facility has approximately 30 cameras covering most common areas.

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## Medical

**Type of Medical Facility:** Basic nursing needs on site; referred off site

**Forensic sexual assault medical exams are conducted at:** University Hospital

## Other

<b>Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:</b>	57
<b>Number of investigators the agency currently employs to investigate allegations of sexual abuse:</b>	1

## 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.*

This report is one of three reports for the Applewhite Recovery Center. The facility requested a separate audit and report for each of its three programs; Substance Abuse Treatment Facility, Intermediate Sanction Facility and Mentally Impaired Offender Facility. Much of the substance of each of the three reports is identical as all three programs are within the umbrella of ARC with many of the same staff assigned. Distinguishing characteristics of each program will be specifically identified.

The on-site PREA Audit of the three identified programs of Applewhite Recovery Center (ARC) was conducted on March 13 & 14, 2019. The audit was conducted by Dave Cotten, a certified National PREA auditor under contract with PREA Auditors of America. This is ARC's first National PREA Audit. Approximately six weeks prior to the on-site visit, ARC posted notifications of the upcoming audit with the auditor's contact information to allow for residents to contact the auditor prior to the audit. ARC 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. The file documentation provided was minimal and lacked sufficient information to indicate policy/document compliance. It was apparent the facility not properly prepared for the audit process and/or had not been properly prepared by the governing body. As will be noted in the following compliance report, numerous corrective actions were required with some requiring a corrective action period to complete and some to show a pattern of compliance.

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

An initial in-brief was held at 9:00 a.m. on 3/13/19 with Chief Probation Officer Jarvis Anderson, Facility Director/Assistant Chief Rita Garcia, PREA Coordinator Mark Herrera, Cynthia Cano, General Counsel and Ivonne Chavez, Director of Human Resources. Staff introduced themselves and provided professional background as did the auditor. The in-brief was held at the agency office, downtown San Antonio at Mr. Anderson's request. The Director provided the auditor with an overview of the ARC and the resident population it serves. Mr. Anderson was then interviewed as the agency head and the director of HR was then interviewed.

PREA Coordinator, Mr. Herrera and the auditor then relocated to the confinement facility. The auditor was given a complete tour of the facility. Throughout the tour, the auditor observed the notices of this PREA audit in all the buildings, as well as posters that called attention to the facility's Zero Tolerance Policy and how to report allegations of sexual abuse and sexual harassment. Some staff toilet areas, where residents access occasionally were found to be not lockable from the outside or were not key operated so could be locked from the inside, but not accessible from the outside even with a key. Recommendations were made to place staff key operated locks on the staff toilet areas. Medical isolation room (temporary holding) toilet is under

camera view. Auditor recommended the camera position be changed to allow for security viewing, but not opposite gender viewing of residents in the isolation area. Some shower areas would benefit from curtains or other barriers to assist in minimizing possible staff of the opposite gender viewing of residents in a state of undress. The facility would benefit with more visible PREA related posters, in efforts to further protect residents from sexual abuse. Some camera views were questioned by the auditor. Camera views were shown to the auditor to be appropriate or the view was slightly adjusted to meet standard. One area in the exercise yard was found to be a large blind spot. Staff recognized the need for an additional camera for that area and began the purchasing process. The auditor did notice no phones were available for resident use. When questioned, staff indicated residents were not allowed phone calls except when approved by the counselor or higher authority.

Following the tour, the auditor began the interviews and reviews of on-site documents.

Twenty (20) residents were interviewed with two (3) being housed in the ISF program, five (5) from the MIOF program and 12 from the SATF program. Those interviewed were randomly selected, by the auditor, from a list of all the offenders by their housing assignment at the facility. Three of the 20 residents interviewed identified as LGBTI.

Twelve (12) random staff were interviewed who were randomly selected by the auditor from all shifts and areas. Nine (9) on-site on-site interviews were conducted with specialized staff. On-site interviews included the Agency Director, PREA Coordinator, facility director designee, a medical professional (on-site nurse), the human resources manager, intake staff, facility investigator and first responder staff.

The auditor also interviewed one contractor. In total, twenty-one (21) staff/contractor/volunteer interviews were conducted as part of the audit. At the time of the on-site visit, ARC did not complete risk assessments, conduct incident reviews or monitor for retaliation, therefore no interviews were conducted in those areas. It should be noted that since this is a small facility, some of the employees have multiple responsibilities so some individuals were interviewed more than once if their duties covered more than one specialized area.

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

When the on-site audit was completed, the auditor conducted a short de-brief on March 14, 2019 with Mr. Ms. Garcia and Mr. Herrera. 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.*

Applewhite Recovery Center is a 300-bed facility housing both male and female adult residents based on commitment directed by county and district judges through the probation department. There are three distinct and separate programs within the facility. Each program is housed and programed separately. Males and females are separated by staff only operated locked doors with remote access from control rooms or supervisor only keys. The average daily population is 209 for the last twelve months with 156 male residents and 61 female residents (217 total) on the first day of the on-site. ARC is comprised of four

buildings with only one building housing residents in six (6) open bay dorms. Female and male residents are not allowed to intermingle and are separated by locked, staff only operated door. Similarly, residents assigned to each program are kept separate.

The Mentally Impaired Offender Facility, at the time of the on-site tour, had 32 male residents and 27 female residents for a total of 59. MIOF residents are kept separate from all other residents and females are kept separate from males. Female MIOF residents are all housed in a single dorm with no other residents housed in that dorm. Male MIOF residents are housed in a single dorm with no other program residents within those dorms.

The ARC facility does have a perimeter fence with entries that are controlled by staff only keys, coded key pad or remotely by 24 hours a day manned entry point. Entry into the administrative area is also staff controlled by key, key pad or remotely.

The facility, as a community corrections, has limited, nurse only on-site medical services and no on-site criminal investigators and one administrative investigator.

Overall the camera system is very good with cameras covering the open bay dorms, most hallways and common areas. Residents are told to not be in a state of undress within the bay and must go to the shower/toilet area to dress or undress.

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

## Summary of Audit Findings

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

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

**Number of Standards Exceeded:** zero (0)

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**Number of Standards Met:** Thirty-one (31)

115.211, 115.212, 115.213, 115.215, 115.216, 115.217, 115.218, 115.231, 115.232, 115.233, 115.234, 115.235, 115.241, 115.242, 115.251, 115.253, 115.254, 115.261, 115.262, 115.264, 115.266, 115.267, 115.271, 115.272, 115.273, 115.277, 115.278, 115.287, 115.288, 115.401 & 115.403

**Number of Standards Not Met:** Ten (10)

115.221, 115.222, 115.252, 115.263, 115.265, 115.276, 115.282, 115.283, 115.286, & 115.289

## Summary of Corrective Action (if any)

Due to numerous standards not originally meeting standard, the facility was under a corrective action plan (CAP) not to exceed 180 days from the submission of the interim report to the facility on April 24<sup>th</sup>, 2019. The final report must be submitted to the facility and the Department of Justice through the PREA Resource Center prior to November 21, 2019 to allow for the CAP completion date of October 21, 2019 and 30 days to file the report. However, the final report can be filed at anytime prior to that should the agency/facility show it meets all elements of all standards. As noted below at least one corrective action required a “pattern of compliance” to show the facility meets the standard consistently over a given period of time. Actions taken and final findings on each of the corrective actions listed in this summary are addressed in each individual standard.

The agency and/or facility had corrective actions in twenty-six (26) separate standards as listed below and provided to the facility in the interim report on April 24, 2019. Many of the issues needing addressed were discussed in person, on the phone or via e-mail prior to and after the interim report was submitted.

Applewhite Recovery Center Intermediate Sanctions Facility, along with the other two programs, addressed sixteen (16) of those standards to meet standard. Of the remaining ten (10), some were partially addressed but not to the point of fully meeting the standard and some were not addressed.

**Corrective Action:** 115.213---ARC needs to provide a written staffing plan addressing all elements of standard 115.213 (a) and provide verification of any deviations to the staffing plan or file documentation that no deviations occurred. Facility staff are referred to the PREA Resource Center’s white paper on “Developing and Implementing a PREA-Compliant Staffing Plan” Element (c) also needs addressed by providing written documentation verifying: Whenever necessary, but no less frequently than once each year, the facility shall assess, determine, and document whether adjustments are needed to:

- (1) The staffing plan established pursuant to paragraph (a) of this section;
- (2) Prevailing staffing patterns;
- (3) The facility’s deployment of video monitoring systems and other monitoring technologies; and
- (4) The resources the facility has available to commit to ensure adequate staffing levels.

**Corrective actions:** 115.215--ARC needs to update policy to reflect:  
The facility has policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks. (specifically address female staff only monitor in female dorms and male staff only monitor in male dorms)

The facility requires 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?

The facility always refrains from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident’s genital status.

If a resident’s genital status is unknown, the facility determines 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.

ARC also needs to provide documentary verification that all staff who perform searches have received transgender/intersex pat search training. (training curriculum and sign in sheets)

**Corrective actions:** 115.216-- Provide policy and other documentation that the facility: takes 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, are blind or have low vision, who have speech disabilities or who have intellectual disabilities.

**Corrective Action:** 115.217—MIOF and ARC need to provide policy to reflect compliance with each element of this standard and implement and provide other documentation to verify meeting the elements.

(a) The agency shall not hire or promote anyone who may have contact with residents, and shall not enlist the services of any contractor who may have contact with residents, who—

(1) 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);

(2) 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

(3) Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section.

(b) The agency shall consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.

(c) Before hiring new employees who may have contact with residents, the agency shall:

(1) Perform a criminal background records check; and

(2) 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.

(d) The agency shall also perform a criminal background records check before enlisting the services of any contractor who may have contact with residents.

(e) The agency shall 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.

(f) The agency shall also 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 and in any interviews or written self-evaluations conducted as part of reviews of current employees. The agency shall also impose upon employees a continuing affirmative duty to disclose any such misconduct.

(g) Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

(h) Unless prohibited by law, the agency shall 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.

All current staff need to be informed of the above requirements and complete/sign an acknowledgement of elements (f) & (g).

**Corrective Actions:** 115.221--(1) Facility needs to provide documentation verifying the use of a uniform evidence protocol. MOU with local law enforcement (or attempt at securing an MOU) is needed

to include the use of a uniform evidence protocol. (2) MOUs (or attempts at securing MOUs) is needed for SANE for compliance.

**Corrective actions:** 115.222—(1) The agency/facility/program needs to provide on its website or, if it does not have one, through other means: the policy and practice that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. Provide auditor with verification of completion.

**Corrective action:** 115.231--Develop and implement a staff acknowledgement form indicating staff have received and understand the training received. All current staff need to complete the form and sign acknowledging their most recent training and their understanding of that training. Implement for all future trainings.

**Corrective action:** 115.232-- Develop and implement a volunteer/contractor acknowledgement form indicating they have received and understand the training received. All current volunteers/contractors need to complete the form and sign acknowledging their most recent training and their understanding of that training. Implement for all future trainings.

**Corrective action:** 115.233--The facility needs to ensure methods for providing residents the required education in formats accessible to all residents, including those who are deaf or hearing impaired, visually impaired or have other disabilities or have limited reading skills. Documentation needs to be provided to the auditor verifying these methods are in place.

**Corrective Actions:** 115.241--(1) Per discussion with the auditor, to establish a pattern of compliance (which has not occurred in the past) the facility will:

- (a) develop and implement a screening tool to address all elements of this standard;
- (b) re-assess all current residents using the newly developed screening tool to address all elements of this standard for initial risk screening. Evaluate each for risk of victimization and abusiveness using the information to address standard 115.242;
- (c) begin using the newly developed screening tool to screen all new arrival residents using the information to address standard 115.242 and
- (d) using the newly developed screening tool or similar tool/method to reassess all new arrival residents within 30 days of completion of the initial screening tool.

Facility will notify the auditor when the newly developed screening tool(s) are developed, and the process implemented.

Facility will notify the auditor when all current residents have been screened using the newly developed tool and provide the auditor with a current resident roster.

Between the 1st and the 5th day of the month following the above implementation, the facility will provide the auditor with a resident roster and a roster of all the previous month's new arrival residents. For the following three months between the 1st and 5th, the facility will provide a list of all new arrival residents for the previous month.

Auditor will identify random residents from above rosters and require completed initial assessments and/or re-assessments for those residents.

Facility will supply required documents by posting to the secure portal and notifying the auditor when documents are uploaded.

When a pattern of compliance of meeting all elements of this standard is established (as determined by the auditor) the auditor will notify the facility. After implementation, a minimum of 90 to 120 days of compliance is required.

- (2) Adjust policy to require initial assessment be completed within 72 hours of arrival and re-assessment be completed within 30 days of initial assessment.
- (3) Adjust policy to require 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.
- (4) Adjust policy to require the facility/agency have in place 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.

**Corrective actions:** 115.242—(1) Ensure compliance with the elements of this standard during implementation and upon completion of standard 115.241. Define how the facility will ensure the separation of those at high risk of victimization from those at high risk of abusiveness in all aspects of elements (a) and (b).

(2) Adjust policy to address the placement and involvement of the LGBTI residents as outlined in elements (c), (d), (e) & (f).

**Corrective action:** 115.251—(1) Provide at least one way for residents to (privately and anonymously) report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency. That entity is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials. The agency/facility is referred to the PREA Resource Center FAQ on standard 115.51(251) for the parameters. (2) Provide in policy a means for staff to privately report as outlined in element (e).

**Corrective actions:** 115.252--Develop and implement policy/procedure to address elements:

(d.2) Computation of the 90-day time period shall not include time consumed by residents in preparing any administrative appeal.

(d.3) The agency may claim an extension of time to respond, of up to 70 days, if the normal time period for response is insufficient to make an appropriate decision. The agency shall notify the resident in writing of any such extension and provide a date by which a decision will be made.

(d.4) 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, the resident may consider the absence of a response to be a denial at that level.

(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, and 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 Provide this information to residents & If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision. While address in policy, there is no indication of this information being provided to the residents.

(f) The initial response and final agency decision shall document the agency's determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance.

(g) The agency may discipline a resident for filing a grievance related to alleged sexual abuse only where the agency demonstrates that the resident filed the grievance in bad faith.

**Corrective actions:** 115.253--Provide verification that the facility informs residents, prior to giving them access to outside victim advocates for emotional support services related to sexual abuse, 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.

**Corrective action:** 115.263--Adjust wording in policy to reflect the notification is made by the facility head or at the direction of the facility head as outlined in the PREA Resource Center FAQs.

**Corrective action:** 115.265--MIOF needs to develop and institute a facility specific coordinated response plan as defined in this standard. 115.265 states: "The facility shall develop a written institutional plan to coordinate actions taken in response to an incident of sexual abuse, among staff first responders, medical and mental health practitioners, investigators, and facility leadership."

**Corrective action:** 115.271--The facility needs to adjust policy to reflect (i) the agency retains 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; and (j) the agency ensures 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.

**Corrective action:** 115.273—Provide examples documentation of notifications being made to residents as outlined in the elements of this standard.

**Corrective action:** 115.276-The facility needs to address, in policy, element (b): termination is the presumptive disciplinary sanction for staff who have engaged in sexual abuse (c): 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; and element (d): 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.

**Corrective actions:** 115.78--Facility policy needs address elements (c) through (g) of this standard. From the standard: (c) The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed.

(d) 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 offending resident to participate in such interventions as a condition of access to programming or other benefits.

(e) The agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact.

(f) For the purpose of disciplinary action, 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.

(g) An agency may, in its discretion, prohibit all sexual activity between residents and may discipline residents for such activity. An agency may not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced.

**Corrective actions:** 115.282--(1) Develop and implement an MOU with local medical agency or organization to provide (at no cost to resident) resident victims of sexual abuse with timely, unimpeded access to emergency medical treatment as outlined in this standard and standard 115.283. Attempts to

enter into the agreements, whether accomplished or not, are to be provided to the auditor. (2) Add element (c) of the standard to the policy and to the noted MOU.

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

Offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility; to include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody;

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

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

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

Attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners.

**Corrective actions:** 115.286--MIOF needs to address this standard in full.

(a) The facility shall 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.

(b) Such review shall ordinarily occur within 30 days of the conclusion of the investigation.

(c) The review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners.

(d) 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; lesbian, gay, bisexual, transgender, or intersex 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; and

(6) Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement, and submit such report to the facility head and PREA compliance manager.

(e) The facility shall implement the recommendations for improvement or shall document its reasons for not doing so.

In discussions with the auditor, the facility will develop policy to address this standard. Policy adjust will be forwarded to the auditor. The auditor strongly recommends the development of an "Incident Review Checklist" to fully address each element of the standard when needed.

**Corrective actions:** 115.287—The agency/facility needs to address this standard in full.

- (a) The agency shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions.
- (b) The agency shall aggregate the incident-based sexual abuse data at least annually.
- (c) The incident-based data collected shall 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.
- (d) The agency shall maintain, review, and collect data as needed from all available incident-based documents including reports, investigation files, and sexual abuse incident reviews.
- (e) The agency also shall obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents.
- (f) Upon request, the agency shall provide all such data from the previous calendar year to the Department of Justice no later than June 30.

**Corrective actions:** 115.288-- The agency/facility needs to address this standard in full.

- (a) The agency shall 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:
  - (1) Identifying problem areas;
  - (2) Taking corrective action on an ongoing basis; and
  - (3) Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole.
- (b) Such report shall include a comparison of the current year's data and corrective actions with those from prior years and shall provide an assessment of the agency's progress in addressing sexual abuse.
- (c) The agency's report shall be 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.
- (d) The agency may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility, but must indicate the nature of the material redacted.

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

- (a) The agency shall ensure that data collected pursuant to § 115.287 are securely retained.
- (b) The agency shall 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.
- (c) Before making aggregated sexual abuse data publicly available, the agency shall remove all personal identifiers.
- (d) The agency shall 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.

## PREVENTION PLANNING

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

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

#### 115.211 (a)

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

#### 115.211 (b)

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

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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

**Policy:** Bexar County Community Supervision & Corrections Department Applewhite Recovery Center (ARC) PREA policy 4.1 states the facility has zero tolerance relating to sexual abuse or harassment... all allegations of sexual abuse or sexual harassment will be fully investigated and referred for prosecution if the conduct violates state criminal laws. Policy further defines prohibited behaviors, sexual abuse and sexual harassment.

The policy goes on to describe its approach to the prevention, detection and response to sexual abuse and harassment.

ARC's 115.212, policy 4.39, PREA Outcries and 1<sup>st</sup> Responder Duties, further describes the approach to the prevention, detection and response to sexual abuse or harassment.

Per PREA policy, the Mentally Impaired Offender Facility Director will act as the PREA Coordinator for the ARC as a whole, and all three programs to include MIOF, and is responsible for the oversight of all PREA related activities.

**Other documentation:** PAQ identifies the PREA Coordinator who reports to the Facility Director. ARC Org chart shows Mr. Herrera as the MIOF Director and PREA Coordinator reporting to the Assistant Chief of Residential Services.

**Interviews:** Mr. Herrera states he has sufficient time to administer PREA for the agency/facility but requires more than a 40 hour week and he is on call 24/7. He described his actions to stay updated on PREA information, refer the PREA Resource Center's website and coordinate the efforts to meet the elements of the standards, thereby addressing sexual abuse/harassment of residents. He states he and the Director have the authority to ensure many updates and changes as needed.

**Findings:** The facility meets the elements of this standard.

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

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

### **115.212 (a)**

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

### **115.212 (b)**

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

### **115.212 (c)**

- If the agency has entered into a contract with an entity that fails to comply with the PREA standards, did the agency do so only in emergency circumstances after making all reasonable attempts to find a PREA compliant private agency or other entity to confine residents? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA

standards.)  Yes  No  NA

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

Not applicable as the MIOF and ARC do not contract for the confinement of residents.

## Standard 115.213: Supervision and monitoring

### 115.213 (a)

- Does the agency develop for each facility a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?  
 Yes  No
- Does the agency document for each facility a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?  
 Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the physical layout of each facility in calculating adequate staffing levels and determining the need for video monitoring?  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the composition of the resident population in calculating adequate staffing levels and determining the need for video monitoring?  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the prevalence of substantiated and unsubstantiated incidents of sexual abuse in calculating adequate staffing levels and determining the need for video monitoring?  Yes  No

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

#### 115.213 (b)

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

#### 115.213 (c)

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the staffing plan established pursuant to paragraph (a) of this section?  Yes  No
- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to prevailing staffing patterns?  Yes  No
- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the facility's deployment of video monitoring systems and other monitoring technologies?  Yes  No
- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the resources the facility has available to commit to ensure adequate staffing levels?  Yes  No

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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

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

**Initial findings:** The facility does not meet the standard. No documentation was provided to verify elements (a) through (c) above. There is no written staffing plan and no indication that there were any deviations to the staffing plan or if deviations did occur, no documentation or justifications.

**Corrective Action:** 115.213---ARC needs to provide a written staffing plan addressing all elements of standard 115.213 (a) and provide verification of any deviations to the staffing plan or file documentation that no deviations occurred. Facility staff are referred to the PREA Resource Center’s white paper on “Developing and Implementing a PREA-Compliant Staffing Plan” Element (c) also needs addressed by providing written documentation verifying: Whenever necessary, but no less frequently than once each year, the facility shall assess, determine, and document whether adjustments are needed to:

- (1) The staffing plan established pursuant to paragraph (a) of this section;
- (2) Prevailing staffing patterns;
- (3) The facility’s deployment of video monitoring systems and other monitoring technologies; and
- (4) The resources the facility has available to commit to ensure adequate staffing levels.

**Action taken:** ARC provided the auditor with the 2019 staffing plan, dated October 14, 2019. The provided document, while unsigned, addresses element (a) of the standard.

The plan is formalization of past staffing and facility reports no deviations from the staffing has occurred. The staffing plan itself requires deviations be reported immediately through a written report. The staffing plan also requires an annual review of the recently developed plan to address element (c).

**Final findings:** During the CAP, the facility provided a formal staffing plan to the auditor and reported no deviations had occurred to the informal staffing within the last 12 months. With the formal staffing plan just being implemented due to this audit, there can be no annual reviews of that report. With the facility meeting the intent of the standard by producing a formal staffing plan and providing in policy that annual reviews will occur, the facility now meets this standard. The sub-elements of element (c) above will remain checked no but does not affect the final finding.

## Standard 115.215: Limits to cross-gender viewing and searches

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

#### 115.215 (a)

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

#### 115.215 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches of female residents, except in exigent circumstances? (N/A if less than 50 residents)  
 Yes  No  NA
- Does the facility always refrain from restricting female residents’ access to regularly available programming or other outside opportunities in order to comply with this provision? (N/A if less than 50 residents)  Yes  No  NA

#### 115.215 (c)

- Does the facility document all cross-gender strip searches and cross-gender visual body cavity searches?  Yes  No
- Does the facility document all cross-gender pat-down searches of female residents?  Yes  No

#### 115.215 (d)

- Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks?  Yes  No
- Does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing?  Yes  No

#### 115.215 (e)

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status?  Yes  No
- If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner?  Yes  No

#### 115.215 (f)

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

#### Auditor Overall Compliance Determination

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

## Instructions for Overall Compliance Determination Narrative

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

**Policy:** ARC SOP 4.26, Resident strip/pat searches, states ARC SOP 4.26, Resident strip/pat searches, states: All strip searches will be conducted by a Senior Shift Leader /Shift Leader (SSL/SL) or Person in Charge (PIC) and a Security Monitor of the same sex.

All strip searches will be documented in the End of Shift Report. The documentation will include the names of the residents who were searched, the reason they were searched and the names of the Security Staff who conducted the search.

**Other documentation:** Power point presentation compiled by the Moss Group titled "Guidance in Cross-gender and transgender pat Searches"

**Interviews and observations:** The director states there have been no such searches conducted requiring documentation. All random staff stated they have never seen a female resident have to wait for a female staff to search them when required. Staff also know they would not search a resident to determine their genital status. Random staff stated they do announce themselves when entering a living unit of residents of the opposite gender and must be cleared by the same sex staff working that specific dorm after residents have been advised of an opposite sex staff entering the dorm. Random residents interviewed stated rarely, if ever, hear staff of the opposite gender announce themselves, but also rarely see staff of the opposite gender enter their dorm area. No residents felt they were ever in a position that they had to be in a state of undress, use the toilet or shower with staff of the opposite gender viewing them. All staff indicated they had recently received training on cross gender and transgender/intersex searches.

**Initial findings:** The facility does not meet the standard as no documentation was provided to address elements (d), (e) or (f).

**Corrective actions:** 115.215--ARC needs to update policy to reflect:

The facility has policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks. (specifically address female staff only monitor in female dorms and male staff only monitor in male dorms)

The facility requires 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?

The facility always refrains from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status.

If a resident's genital status is unknown, the facility determines 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.

ARC also needs to provide documentary verification that all staff who perform searches have received transgender/intersex pat search training. (training curriculum and sign in sheets)

**Action taken:** Update search training for all staff states “residents who identify as transgender will not be strip searched except by medical staff.”

Staffing Plan requires all male staff entering a female housing unit must knock and announce and not enter the unit until cleared by the female staff supervising the unit (except in emergency). Female staff entering a male housing unit must knock and announce. Residents are instructed to be covered in the housing unit.

The facility provided an updated training and training rosters to reflect cross gender training has occurred.

**Final findings:** Based on the above actions taken, the facility now meets all 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**

*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:** ARC SOP 4.39 does prohibit the use of resident interpreters, etc....

**Other documentation:** Client PREA Acknowledgement Form.

**Interviews and observations:** Three residents were identified as LEP during the random resident interviews. The residents stated they were given all the PREA information through a staff translator and they were knowledgeable of the PREA information as they completed the questions asked. Random staff generally knew they are never to use another resident to translate but did not know if it was in policy or written procedure.

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

The facility does not accept clients who are deaf, visually impaired or disabled to the point of not being able to perform work activities.

**Initial findings:** Nothing provided indicates the facility has policy or actually practices providing clients with disabilities as listed in element (a) or (b) the information in formats that they could understand.

**Corrective actions:** 115.216-- Provide policy and other documentation that the facility: takes 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, are blind or have low vision, who have speech disabilities or who have intellectual disabilities.

**Actions Taken:** None noted.

**Final findings:** The facility does not accept clients who are deaf, visually impaired or disabled to the point of not being able to perform work activities. Auditor recommends this be placed into policy. The facility does provide interpreters or staff provide the information, one on one, for low functioning residents as needed based on the above interview with the LEP residents and interviews with staff. Upon re-assessment by the auditor, the agency /facility meets this standard. Specific elements will remain checked "no" as they do not apply to this facility and do not affect the final finding.

## **Standard 115.217: Hiring and promotion decisions**

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

### **115.217 (a)**

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?  Yes  No
- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?  Yes  No
- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above?  Yes  No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?  Yes  No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?  Yes  No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above?  Yes  No

#### 115.217 (b)

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

#### 115.217 (c)

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

#### 115.217 (d)

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

#### 115.217 (e)

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

#### 115.217 (f)

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions?  Yes  No
- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees?  Yes  No
- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct?  Yes  No

#### 115.217 (g)

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

#### 115.217 (h)

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

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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

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

**Policy:** County of Bexar policies 1.1 & 1.27 requires background checks be conducted on new hires.

**Other documentation:** Current background packet

**Interviews and observations:** HR staff indicate all staff have had backgrounds completed and a data base will be implemented to ensure all staff, contractors and volunteers will be completed as the standard requires.

**Initial findings:** Does not meet standard. While policy and other documentation reflect background checks are completed on new hires and history of arrests, detentions and litigations is asked, the specific questions and requirements, as outlined in this standard, are not addressed. New hires are informed that willful misrepresentations, omissions or falsifications could result in rejections or termination.

**Corrective Action:** 115.217—ISF and ARC need to provide policy to reflect compliance with each element of this standard and implement and provide other documentation to verify meeting the elements.

(a) The agency shall not hire or promote anyone who may have contact with residents, and shall not enlist the services of any contractor who may have contact with residents, who—

(1) 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);

(2) 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

(3) Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section.

(b) The agency shall consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.

(c) Before hiring new employees who may have contact with residents, the agency shall:

(1) Perform a criminal background records check; and

(2) 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.

(d) The agency shall also perform a criminal background records check before enlisting the services of any contractor who may have contact with residents.

(e) The agency shall 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.

(f) The agency shall also 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 and in any interviews or written self-evaluations conducted as part of reviews of current employees. The agency shall also impose upon employees a continuing affirmative duty to disclose any such misconduct.

(g) Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

(h) Unless prohibited by law, the agency shall 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.

All current staff need to be informed of the above requirements and complete/sign an acknowledgement of elements (f) & (g).

**Actions taken:** ARC provided updated policy 1.27 requiring all the elements of the corrective action be address in the hiring process as follows.

### **Applewhite Recovery Center Employee Screening**

The Department shall not hire or promote anyone at its Applewhite Recovery Center, who may have contact with residents, or retain the services of any contractor who may have contact with residents, who:

(a) Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution as defined by 42 U.S.C. 1997; or

(b) Has been convicted of, or civilly or administratively adjudicated for, engaging or attempting to engage in sexual activity in the community facilitated by force, threats of force, or coercion, or if the victim did not consent or was unable to consent.

The Department shall consider any incidents of sexual harassment in determining whether to hire or promote anyone at its Applewhite Recovery Center, or to retain the services of any contractor, who may have contact with residents.

Before hiring new employees at its Applewhite Recovery Center who may have contact with residents, the Department shall:

(a) Perform a criminal background records check; and

(b) 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.

The Department shall also perform a criminal background records check before retaining the services of any contractor who may have contact with residents at its Applewhite Recovery Center.

The Department shall either conduct criminal background records checks at least every five years of current employees and contractors at its Applewhite Recovery Center who may have contact with residents or have in place a system for otherwise capturing such information for current employees.

The Department shall ask all applicants and employees who may have direct contact with residents about previous misconduct described in this section, in:

(a) Written applications and/or interviews for hiring or promotion; and

(b) Interviews or written self-evaluations conducted as part of reviews of current employees.

The Department shall impose on its current employees a continuing affirmative duty to disclose any of the misconduct described in this section. Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

Unless prohibited by law, the Department shall 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.

**Final finding:** While the facility provided updated policy to address applicants and employees, the element—

(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? & 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?

requires all employees be asked the relative questions. This was addressed in the corrective action as well. No documents were provided to verify this for employees. However, upon review of the PREA Resource Center website FAQ response to a question: If the agency does not use written applications, written self-evaluations, or conduct interviews under the circumstances indicated in standard 115.17(f), it has no obligation under this standard to begin these practices. However, the agency does have the obligation to establish a continual affirmative duty to disclose misconduct. The agency must impose on employees the affirmative duty to report any misconduct described in standard 115.17(a) [i.e., paragraph (a) of the standard] at any time that it occurs. Therefore, requiring all staff to read and sign should be accomplished but is not cause for not meeting the standard.

The facility has not provided documentation of background checks being completed. During the interview stage the auditor was informed a tracking data base would be developed for this purpose which could be provided to the auditor without sensitive information, found on the actual background checks, being divulged. Again, this alone is not cause for not meeting the standard but should be accomplished.

As the Human Resources staff did state all staff have had background checks completed and all were within 5 years and review of files on site did confirm background checks on those reviewed. The facility meets this element and the standard as a whole.

## Standard 115.218: Upgrades to facilities and technologies

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

#### 115.218 (a)

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

#### 115.218 (b)

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

**Auditor Overall Compliance Determination**

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

**Instructions for Overall Compliance Determination Narrative**

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

**Policy:** None

**Other documentation:** None

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

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

**RESPONSIVE PLANNING**

**Standard 115.221: Evidence protocol and forensic medical examinations**

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

**115.221 (a)**

- If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not

responsible for conducting any form of criminal OR administrative sexual abuse investigations.)  
 Yes  No  NA

#### 115.221 (b)

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

#### 115.221 (c)

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate?  Yes  No
- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible?  Yes  No
- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)?  Yes  No
- Has the agency documented its efforts to provide SAFEs or SANEs?  Yes  No

#### 115.221 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center?  Yes  No
- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member?  Yes  No
- Has the agency documented its efforts to secure services from rape crisis centers?  
 Yes  No

#### 115.221 (e)

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

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

#### 115.221 (f)

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

#### 115.221 (g)

- Auditor is not required to audit this provision.

#### 115.221 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.221(d) above.)  Yes  No  NA

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

#### **Policy:** ARC SOP 4.39 states:

General Investigation Policy: Except for those cases referred for criminal investigation, the ARC shall conduct investigations of all allegations of sexual abuse, sexual harassment and, or retaliation in a prompt, thorough, and objective manner, including third-party and anonymous reports. Complaints of sexual assault (rape) shall not be investigated by the ARC, but immediately reported to the Bexar County Sheriff's Department as provided by First Responder protocol. The PREA Coordinator will monitor and ensure that sexual abuse criminal investigations referred to law enforcement are timely addressed and investigated.

Policy goes on to say:

- a. Administrative or criminal investigations shall be completed for all allegations of sexual abuse, sexual harassment, retaliation and, or allegations of staff neglect or violation of responsibilities that may have contributed to incidents of sexual abuse, sexual harassment and, or retaliation.
- b. Allegations of sexual abuse involving allegations of sexual assault (rape) shall be referred to the Bexar County Sheriff's Department for investigation.
- c. The PREA Coordinator shall coordinate the investigation of complaints, logging assignment of the investigation and tracking completion of the investigation stages.
- d. Investigators shall gather and preserve evidence, including, but not limited to, videotapes, logs, emails and other written documents pertinent to the allegations. Investigators shall interview the complainant, alleged perpetrator and named and potential witnesses, utilizing a tape recorder to document all testimony.
- e. Investigators shall log all interactions and evidence collected, identifying the nature and date of the interaction and, or evidence collected.
- f. Investigators shall utilize Garrity Warnings when interviewing staff alleged to have engaged in acts of sexual abuse (other than sexual assault), sexual harassment or retaliation rising to the level of violations of the State official oppression statute where applicable.
- g. After a prompt thorough, and objective investigation of the facts, Investigators shall prepare an investigation report in all cases. A finding shall be made based upon a preponderance of the evidence standard. The report should document the allegations, evidence and testimony, analysis of the evidence gathered, credibility assessments of parties and witnesses, and findings. Findings should be determined to be "unfounded," "unsubstantiated," or "substantiated." Investigators shall also make an effort to determine if staff actions or failures contributed to substantiated findings.
- h. All investigations shall be completed within 90 days of initiation of the complaint process by the resident.
- i. Substantiated allegations shall be addressed through the disciplinary process. Substantiated allegations of conduct that appear to be criminal are referred for prosecution.

**Other documentation:** ARC has an MOU with the Rape Crisis Center for a hotline, emotional support and to provide a victim advocate through the entire process.

**Interviews and observations:** Of the random staff interviewed all knew the local police were responsible for investigating sexual abuse at the facility. Some staff stated the PREA coordinator was responsible for those investigations. Most staff were aware of securing the scene, reporting, isolating the victim and encouraging the victim to not do anything that could compromise evidence, such as changing clothes, showering, drinking anything, etc.,. An interview with the assigned administrative investigator indicates he is well trained and knowledgeable of his role as investigator and/or liaison with local law enforcement.

**Initial findings:** The facility does not meet the standard as addressed in the corrective action below. (1) No documentation provided to indicate a uniform protocol is used for evidence by either criminal investigators or administrative investigators. (2) No means of providing SANE is addressed.

**Corrective Actions:** 115.221--(1) Facility needs to provide documentation verifying the use of a uniform evidence protocol. MOU with local law enforcement (or attempt at securing an MOU) is needed to include the use of a uniform evidence protocol. (2) MOUs (or attempts at securing MOUs) is needed for SANE for compliance.

**Action taken:** (1) No action provided. (2) The facility provided an MOU, signed 4/17/19, with Methodist Healthcare Systems of San Antonio LTD. LLP to conduct SANE for all Applewhite residents as necessary

**Final findings:** ARC now has an MOU with Methodist Healthcare of San Antonio to provide SANE as requested 24 hours a day at no cost to the resident for victims of sexual abuse at the facility.

No documentation was provided to address (1) of the corrective action which relates to element (a) & (b) of this standard. The facility must show evidence of the use of a uniform evidence protocol for administrative investigations and: from the PREA Resource Center FAQs-- Under standard 115.21, the agency (a private, federal, state, county, or other local entity) being audited must demonstrate to the auditor that it has attempted to gain compliance from an external entity that conducts criminal investigations of sexual abuse with requirements (a) through (e) of that standard—that is, the agency being audited must have requested that the external entity responsible for investigations comply with all those provisions described in (a) through (e) of standard 115.21.

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

Therefore, the facility does not meet elements (a) & (b) of this standard.

## Standard 115.222: Policies to ensure referrals of allegations for investigations

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

#### 115.222 (a)

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

#### 115.222 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior?  Yes  No
- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means?  Yes  No
- Does the agency document all such referrals?  Yes  No

#### 115.222 (c)

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

#### 115.222 (d)

- Auditor is not required to audit this provision.

#### 115.222 (e)

- Auditor is not required to audit this provision.

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

**Policy:** ARC SOP 4.1 states: Moreover, all allegations of sexual abuse and sexual harassment will be fully investigated, sanctioned (if appropriate), and referred for prosecution if the prohibited conduct violates State/Federal criminal laws.

ARC SOP 4.39 states: Allegations of sexual abuse involving allegations of sexual assault (rape) shall be referred to the Bexar County Sheriff's Department for investigation; and, the PREA Coordinator shall coordinate the investigation of complaints, logging assignment of the investigation and tracking completion of the investigation stages.

**Interviews and observations:** In interviews with the agency head, facility head and PREA coordinator, all stated all allegations are referred to local law enforcement if any indication of criminal activity. The facility does do administrative investigations and has a trained investigator.

**Initial findings:** Does not meet standard: No evidence of public posting as outlined in elements (b) and (c) was provided or was found by the auditor.

**Corrective actions:** 115.222—The agency/facility/program needs to provide on its website or, if it does not have one, through other means: the policy and practice that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct

criminal investigations, unless the allegation does not involve potentially criminal behavior. Provide auditor with verification of completion.

**Action taken:** No action provided.

**Final findings:** As no actions to address the corrective actions noted have been provided to the auditor, the initial finding of not meeting standard remains. A link was found on the Bexar County CSCD website which was reviewed by the auditor however no specific information regarding investigations was found.

## TRAINING AND EDUCATION

### Standard 115.231: Employee training

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

#### 115.231 (a)

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

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

#### 115.231 (b)

- Is such training tailored to the gender of the residents at the employee's facility?  Yes  No
- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa?  Yes  No

#### 115.231 (c)

- Have all current employees who may have contact with residents received such training?  
 Yes  No
- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures?  Yes  No
- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies?  Yes  No

#### 115.231 (d)

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

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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

**Policy:** ARC SOP 4.1 states:

Implementation of this policy shall be achieved through appropriate training of volunteers, contractors and staff, including but not limited to security, medical practitioners, mental health counseling staff and PREA investigators; notice to residents at the intake stage regarding the ARC's zero tolerance policy; implementation of a complaint/investigation process; ongoing notice to residents through published policies and literature, dorm meetings and one-on-one counseling sessions;

3) All employees will attend a PREA Training within 6 months of employment. Training will also be conducted on an annual basis for all employees, volunteers and contractors;

**Other documentation:** Power point training for PREA as adapted from the Moss Groups training.  
Examples of training rosters for staff training  
PREA Acknowledgement form for employees  
PREA Pamphlet

**Interviews and observations:** This facility houses both male and female residents therefore staff are trained appropriately for supervision of both genders. While there is a staff acknowledgement form, it does not document, through employee signature or electronic verification, that employees understand the training they have received.

**Initial findings:** The facility does not meet the standard as there is no documentation verifying staff have received and understand the training.

**Corrective action:** 115.231--Develop and implement a staff acknowledgement form indicating staff have received and understand the training received. All current staff need to complete the form and sign acknowledging their most recent training and their understanding of that training. Implement for all future trainings.

**Action taken:** ARC provided completed and signed employee acknowledgement forms for current staff and future trainings which states:

By signing below you acknowledge the following:

I acknowledge receiving information on the prevention of sexual abuse/harassment and the Bexar County Applewhite Recovery Center's policy on Zero Tolerance of sexual abuse/harassment, in accordance to PREA Standard 115.211 and 115.231. I further acknowledge that I understand the information received in accordance to PREA Standard 115.231 (d)

**Final findings:** Based on the above policy, other documentation, interviews/observations and actions taken, the agency/facility meet this standard.

## Standard 115.232: Volunteer and contractor training

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

### 115.232 (a)

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

### 115.232 (b)

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

### 115.232 (c)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

#### **Policy:** ARC SOP 4.1 states:

Implementation of this policy shall be achieved through appropriate training of volunteers, contractors and staff, including but not limited to security, medical practitioners, mental health counseling staff and PREA investigators; notice to residents at the intake stage regarding the ARC's zero tolerance policy; implementation of a complaint/investigation process; ongoing notice to residents through published policies and literature, dorm meetings and one-on-one counseling sessions;

All employees will attend a PREA Training within 6 months of employment. Training will also be conducted on an annual basis for all employees, volunteers and contractors;

**Other documentation:** Power point training for PREA as adapted from the Moss Groups training.  
Examples of training rosters for volunteer training  
PREA Acknowledgement form for employees  
PREA Pamphlet

**Interviews and observations:** One contractor and one volunteer were interviewed stating they had received PREA training in the last few months. Both described portions of the training to include zero tolerance, how to report to staff, supervisors, local law enforcement, PREA hotline.

**Initial findings:** Facility does not meet the standard, element (c), the agency maintains documentation confirming that volunteers and contractors understand the training they have received.

**Corrective action:** 115.232-- Develop and implement a volunteer/contractor acknowledgement form indicating they have received and understand the training received. All current volunteers/contractors need to complete the form and sign acknowledging their most recent training and their understanding of that training. Implement for all future trainings.

**Action taken:** ARC provided "PREA Acknowledgement Forms" completed by contractors/volunteers that contains a statement that they fully understand the elements of the training and is signed.

**Final findings:** Based on policy, other documentation, interviews/observations and the above actions taken, the facility now meets all elements of this standard.

## Standard 115.233: Resident education

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

#### 115.233 (a)

- During intake, do residents receive information explaining: The agency's zero-tolerance policy regarding sexual abuse and sexual harassment?  Yes  No
- During intake, do residents receive information explaining: How to report incidents or suspicions of sexual abuse or sexual harassment?  Yes  No
- During intake, do residents receive information explaining: Their rights to be free from sexual abuse and sexual harassment?  Yes  No
- During intake, do residents receive information explaining: Their rights to be free from retaliation for reporting such incidents?  Yes  No
- During intake, do residents receive information regarding agency policies and procedures for responding to such incidents?  Yes  No

#### 115.233 (b)

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

#### 115.233 (c)

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

- Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired?  Yes  No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are otherwise disabled?  Yes  No
- Does the agency provide resident education in formats accessible to all residents, including those who: Have limited reading skills?  Yes  No

#### 115.233 (d)

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

#### 115.233 (e)

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

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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

**Policy:** ARC SOP 4.4 states:

The Senior Shift Leader/Shift Leader will read and explain the Facility Rules and Regulations to include the PREA Acknowledgement Form. The Senior Shift Leader /Shift Leader and resident will sign all required documents. Intake documents are to be completely filled out by each resident.

**Other documentation:** Clients rights form states clients have a right to a humane and safe environment free from abuse, neglect and exploitation.

An PREA Acknowledgement of Understanding form (blank) addresses zero tolerance, facility responses to abuse, and defines prohibited behaviors, resident on resident sexual abuse and staff sexual misconduct.

PREA Flyer “What is PREA” which addresses zero tolerance, client rights to free from sexual abuse, harassment, retaliation for reporting and the right to be educated and informed regarding agency policies and procedures for responding to sexual abuse. Flyer also identifies ways to report by telling a staff member or the grievance process via a locked box.

**Interviews and observations:** Interviews with intake staff indicate all residents receive an intake packet containing the flyer and PREA acknowledgement forms, they watch the PREA orientation video from the Resource Center and the issues is discussed with questions as needed. Intake always happens within 72 hours. All incoming residents receive the same orientation regardless or where they are coming from.

Almost all residents interviewed stated they had received PREA information upon arrival. They were aware of the posters and the flyer information.

Three LEP residents were interviewed and stated he did receive the information in a manner he could understand.

**Initial findings:** The facility does not meet the element of (c) of the standard. Nothing provided in the file documentation indicates the facility’s methods for providing residents the required education in formats accessible to all residents, including those who are deaf or hearing impaired, visually impaired or have other disabilities or have limited reading skills.

**Corrective action:** 115.233--The facility needs to ensure methods for providing residents the required education in formats accessible to all residents, including those who are deaf or hearing impaired, visually impaired or have other disabilities or have limited reading skills. Documentation needs to be provided to the auditor verifying these methods are in place.

**Action taken:** No actions were provided to the auditor.

**Final findings:** The facility does not accept clients who are deaf, visually impaired or disabled to the point of not being able to perform work activities. Auditor recommends this be placed into policy. The facility does provide interpreters or staff provide the information, one on one, for low functioning residents as needed based on the above interview with the LEP residents and interviews with staff. Upon re-assessment by the auditor, the agency /facility meets this standard. Specific elements will remain checked “no” as they do not apply to this facility and do not affect the final finding.

## Standard 115.234: Specialized training: Investigations

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

#### 115.234 (a)

- In addition to the general training provided to all employees pursuant to §115.231, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).]  Yes  No  NA

### 115.234 (b)

- Does this specialized training include: Techniques for interviewing sexual abuse victims? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).]  Yes  No  NA
- Does this specialized training include: Proper use of Miranda and Garrity warnings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).]  Yes  No  NA
- Does this specialized training include: Sexual abuse evidence collection in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).]  Yes  No  NA
- Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).]  Yes  No  NA

### 115.234 (c)

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

### 115.234 (d)

- Auditor is not required to audit this provision.

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

**Other documentation:** Facility investigator FBI training certificate for managing and conducting interval affaires investigation.

Facility investigator certificates for completion of NIC's PREA Coordinator's Roles and Responsibilities and PREA: Investigating Sexual Abuse in a Confinement Facility.

**Interviews and observations:** In interviews with the Facility Director and PREA Coordinator/Investigator: Criminal allegations are referred to local law enforcement. (Bexar County Sheriff). Some random staff were aware of this and other random staff stated the PREA Coordinator or Facility Director were responsible for all investigations. Interview with investigator, who investigates allegations from all three programs, indicates he has received the appropriate training and is very knowledgeable.

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

## Standard 115.235: Specialized training: Medical and mental health care

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

### 115.235 (a)

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

### 115.235 (b)

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

### 115.235 (c)

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

### 115.235 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231?  Yes  No
- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? [N/A for circumstances in which a particular status (employee or contractor/volunteer) does not apply.]  
 Yes  No  NA

**Auditor Overall Compliance Determination**

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

**Instructions for Overall Compliance Determination Narrative**

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

**Other documentation:** Training records for PREA training.

**Interviews and observations:** In interviewing the PREA Coordinator and medical staff, the medical staff at ARC are basic first aid only and/or referral to off-site medical agencies. Medical staff are not involved in the intake process and would offer only emergent first aid for a victim of sexual abuse as the victim would be transferred to an off-site agency for treatment.

The facility does not conduct SANE.

In an interview with one assigned nurse, he states he has had PREA training at the facility but not medical/mental health specific training. His training is the same as all employees or contractors.

**Findings:** The facility does not employ medical staff for any treatments except basic first aid and triage. Due to not being applicable to this facility, the standard is met.

**SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS**

**Standard 115.241: Screening for risk of victimization and abusiveness**

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

#### 115.241 (a)

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

#### 115.241 (b)

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

#### 115.241 (c)

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

#### 115.241 (d)

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has a mental, physical, or developmental disability?  Yes  No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The age of the resident?  Yes  No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The physical build of the resident?  Yes  No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously been incarcerated?  
 Yes  No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident's criminal history is exclusively nonviolent?  
 Yes  No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has prior convictions for sex offenses against an adult or child?  Yes  No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming (the facility affirmatively asks the resident about his/her sexual orientation and gender identity AND makes a subjective determination based on the screener's perception whether the resident is gender non-conforming or otherwise may be perceived to be LGBTI)?  Yes  No

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

#### 115.241 (e)

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

#### 115.241 (f)

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

#### 115.241 (g)

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

#### 115.241 (h)

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

#### 115.241 (i)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

**Policy:** Updated during CAP—Policy 4.4 requires assessments be completed per the standard.

#### Other documentation:

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

**Initial findings:** Does not meet the standard. (1) MIOF has not screened for risk of victimization or abusiveness.  
(2) No requirement can be found requiring the screening tool be completed within 72 hours of arrival (element (b)).  
(3) Nothing in file to indicate compliance with elements (h) which requires 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.  
(4) Nothing in file to indicate compliance with (i) which requires the agency to implement 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.

**Corrective Actions:** 115.241--(1) Per discussion with the auditor, to establish a pattern of compliance (which has not occurred in the past) the facility will:  
(a) develop and implement a screening tool to address all elements of this standard;  
(b) re-assess all current residents using the newly developed screening tool to address all elements of this standard for initial risk screening. Evaluate each for risk of victimization and abusiveness using the information to address standard 115.242;

(c) begin using the newly developed screening tool to screen all new arrival residents using the information to address standard 115.242 and

(d) using the newly developed screening tool or similar tool/method to reassess all new arrival residents within 30 days of completion of the initial screening tool.

Facility will notify the auditor when the newly developed screening tool(s) are developed, and the process implemented.

Facility will notify the auditor when all current residents have been screened using the newly developed tool and provide the auditor with a current resident roster.

Between the 1st and the 5th day of the month following the above implementation, the facility will provide the auditor with a resident roster and a roster of all the previous month's new arrival residents. For the following three months between the 1st and 5th, the facility will provide a list of all new arrival residents for the previous month.

Auditor will identify random residents from above rosters and require completed initial assessments and/or re-assessments for those residents.

Facility will supply required documents by posting to the secure portal and notifying the auditor when documents are uploaded.

When a pattern of compliance of meeting all elements of this standard is established (as determined by the auditor) the auditor will notify the facility. After implementation, a minimum of 90 to 120 days of compliance is required.

(2) Adjust policy to require initial assessment be completed within 72 hours of arrival and re-assessment be completed within 30 days of initial assessment.

(3) Adjust policy to require 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.

(4) Adjust policy to require the facility/agency have in place 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.

**Action taken:** On 7/28/19, the facility notified the auditor that all current residents had been re-assessed using the newly created assessment tool.

The facility provided the auditor with rosters for all current residents and the auditor selected random residents to review. The facility provided appropriate risk assessments for those residents.

For the following three months the facility provided a list of identifying all newly assigned residents for the previous months. The roster includes the date the initial assessment is completed and the date of the 30 re-assessment. Policy requires assessments be conducted within 72 hours of arrival for all incoming residents as well as the 30 re-assessment. Residents are then coded on a staff only roster for their level of risk with all assessments and reassessments being reviewed by the PREA Coordinator for appropriate placement.

In follow up interviews, the PREA Coordinator indicated only staff assessing resident and the PREA Coordinator has access to the assessment forms. Staff responsible for placement are only aware of the potential risk, not the reason(s) why. Residents are never disciplined for declining to answer questions on the assessment.

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

## Standard 115.242: Use of screening information

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

#### 115.242 (a)

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

#### 115.242 (b)

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

#### 115.242 (c)

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

#### 115.242 (d)

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

### 115.242 (e)

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

### 115.242 (f)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

**Policy:** No policy in place.

**Other documentation:**

**Interviews and observations:** Staff readily acknowledged they have not screened for abusiveness. With no means of identifying those at risk of victimization and those at risk of abusiveness, the facility

can not effectively keep separate residents to meet elements of this standard. No policy in place to address any elements of the standard.

LBGTI residents interviewed all stated the did not feel they were placed in dedicated housing due to their LBGTI status.

**Findings:** With no policy in place to address the elements of this standard and the lack of appropriate risk assessments, the facility does not meet the standard.

**Corrective actions:** 115.242—(1) Ensure compliance with the elements of this standard during implementation and upon completion of standard 115.241. Define how the facility will ensure the separation of those at high risk of victimization from those at high risk of abusiveness in all aspects of elements (a) and (b).

(2) Adjust policy to address the placement and involvement of the LBGTI residents as outlined in elements (c), (d), (e) & (f).

**Action taken:** On 7/28/19, the facility notified the auditor that all current residents had been re-assessed using the newly created assessment tool.

The facility provided the auditor with rosters for all current residents and the auditor selected random residents to review. The facility provided appropriate risk assessments for those residents.

For the following three months the facility provided a list of identifying all newly assigned residents for the previous months. The roster includes the date the initial assessment is completed and the date of the 30 re-assessment. Policy requires assessments be conducted within 72 hours of arrival for all incoming residents as well as the 30 re-assessment. Residents are then coded on a staff only roster for their level of risk with all assessments and reassessments being reviewed by the PREA Coordinator for appropriate placement.

In follow up interviews, the PREA Coordinator indicated only staff assessing resident and the PREA Coordinator has access to the assessment forms. Staff responsible for placement are only aware of the potential risk, not the reason(s) why. Residents are never disciplined for declining to answer questions on the assessment. While policy does not directly address element (c) of the standard, LBGTI resident would be considered at a higher risk and would be placed on case by case basis in consultation with the PREA Coordinator.

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

## REPORTING

### Standard 115.251: Resident reporting

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

##### 115.251 (a)

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

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

#### 115.251 (b)

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

#### 115.251 (c)

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

#### 115.251 (d)

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

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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

**Policy:** ARC SOP 4.1 states: It is the responsibility of all ARC employees to take immediate action by reporting to a PREA Coordinator or the Assistant Chief of Residential Facilities any knowledge of a possible violation of the Prison Rape Elimination Act.

ARC SOP 4.39 states: The ARC requires 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; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.—and-- Residents, staff and third parties may bring complaints regarding an allegation of sexual abuse, sexual harassment and, or retaliation at any time, regardless of when the incident is alleged to have occurred. Residents, staff and third parties may also bring complaints regarding staff neglect or violation of responsibilities that may have contributed to incidents of sexual abuse, sexual harassment and, or retaliation. All ARC staff are First Responders. Staff are required to report verbal complaints, or those received in writing, to the PREA Coordinator or Assistant Chief of Residential Services immediately, but no later than the end of their shift. Residents, staff and third parties may also directly access the PREA Coordinator with verbal or written complaints. Residents, staff and third parties may submit complaints in writing by submitting a written complaint to a staff member, PREA Coordinator or by depositing a written complaint in a locked PREA complaint box. Only the PREA Coordinators and the Assistant Chief of Residential Services shall have access to the complaint box in order to protect the confidentiality and, or anonymity of the complaints. The PREA Coordinator or the Assistant Chief of Residential Services shall check the PREA complaint box on a daily basis.

**Other documentation:** Flyer given to each client at intake provides internal methods of internal reporting.

Poster with phone number and address for the Rape Crisis Center addresses emotional support, not reporting.

**Interviews and observations:** Auditor observed posters throughout with methods of reporting, but none to a public or private entity not part of the agency.

Interviews with staff and residents indicate all are trained or educated on reporting methods.

A call was placed to the RCC in San Antonio. The responder stated they provided support but did not contact law enforcement or the agency/facility with the report information.

**Initial findings:** Does not meet standard. While several methods of reporting are posted, none could be found in the file or posted or otherwise presented to the residents to address element (b)-- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency; Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials; Does that private entity or office allow the resident to remain anonymous upon request? Flyer provides only internal methods of reporting.

**Corrective action:** 115.251--(1) Provide at least one way for residents to (privately and anonymously) report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency. That entity is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials. The agency/facility is referred to the PREA Resource Center FAQ on standard 115.51(251) for the parameters. (2) Provide in policy a means for staff to privately report as outlined in element (e).

**Action Taken:** ARC provided the auditor with an MOU with the Rape Crisis Center who agrees to: provide and staff a 24 hour sexual assault and sexual harassment hotline number for all ARC residents and to report allegations to the CSCD;  
provide posters, flyers and contact cards with the information to residents;  
provide ARC staff relative training;  
provide a victim advocate for any all aspects of the incident including SANE;  
provide crisis interventions as needed;  
provide referrals to crisis centers or other agencies after release of transfer;  
maintain confidentiality as required;  
respond to written communication from residents.

**Final findings:** Based on the actions above, the agency/facility now meet the elements of this standard. It was found that staff could report privately to the PREA Coordinator, Facility Director or Agency Director.

## Standard 115.252: Exhaustion of administrative remedies

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

#### 115.252 (a)

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

#### 115.252 (b)

- Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.)  Yes  No  NA
- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.)  Yes  No  NA

#### 115.252 (c)

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)  Yes  No  NA
- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)  Yes  No  NA

#### 115.252 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.)  Yes  No  NA
- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.252(d)(3)], does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.)  Yes  No  NA
- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.)  Yes  No  NA

#### 115.252 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)  Yes  No  NA
- Are those third parties also permitted to file such requests on behalf of residents? (If a third-party files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.)  Yes  No  NA
- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)  Yes  No  NA

#### 115.252 (f)

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

- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.)  Yes  No  NA
- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)  Yes  No  NA
- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)  Yes  No  NA
- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)  Yes  No  NA
- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)  Yes  No  NA

### 115.252 (g)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

#### **Policy:** ARC SOP 4.39 states: Complaints

- a. Residents, staff and third parties may bring complaints regarding an allegation of sexual abuse, sexual harassment and, or retaliation at any time, regardless of when the incident is alleged to have occurred. Residents, staff and third parties may also bring complaints regarding staff neglect or violation of responsibilities that may have contributed to incidents of sexual abuse, sexual harassment and, or retaliation.
- b. All ARC staff are First Responders. Staff are required to report verbal complaints, or those received in writing, to the PREA Coordinator or Assistant Chief of Residential Services immediately, but

no later than the end of their shift. Residents, staff and third parties may also directly access the PREA Coordinator with verbal or written complaints.

c. Residents, staff and third parties may submit complaints in writing by submitting a written complaint to a staff member, PREA Coordinator or by depositing a written complaint in a locked PREA complaint box. Only the PREA Coordinators and the Assistant Chief of Residential Services shall have access to the complaint box in order to protect the confidentiality and, or anonymity of the complaints. The PREA Coordinator or the Assistant Chief of Residential Services shall check the PREA complaint box on a daily basis.

d. Residents may make complaints either verbally or in writing, or with assistance of a third party, except as prohibited herein, when a disability or limited English proficiency may require an accommodation for communication purposes.

e. Verbal complaints will be documented by the PREA Coordinator after an initial inquiry and interview within 48 hours of receipt.

f. Residents may utilize third parties, including fellow residents, staff members, attorneys and outside advocates, to assist in filing requests for administrative remedies relating to allegations of sexual abuse and, or sexual harassment and to file such requests on behalf of the resident. In cases where a resident declines third-party assistance in filing a complaint of sexual abuse or sexual harassment, the PREA Coordinator shall document the resident's decision to decline.

g. Upon receipt of a complaint in which it is evident that the resident is subject to a substantial risk of imminent sexual abuse, the PREA Coordinator shall provide an initial response within 48 hours and shall issue an agency decision within 5 calendar days after investigation as provided here on an expedited schedule. Consistent with First Responder protocol, immediate action shall be taken to protect the resident.

h. A victims' advocate through the Rape Crisis Center will be made available to residents bringing complaints of sexual abuse and, or sexual harassment. Residents will be provided with the mailing address and telephone numbers of the Rape Crisis Center, as well as a confidential environment in which to make contact.

i. Under no circumstance shall a resident be referred to or required to submit a complaint of sexual abuse, sexual harassment or retaliation to the staff member who is the subject of the complaint --and--

h. All investigations shall be completed within 90 days of initiation of the complaint process by the resident.

**Other documentation:** "What is PREA" Pamphlet

**Interviews and observations:** The majority of random residents interviewed indicated they knew they could use the grievance system to report sexual abuse.

**Findings:** Does not meet standard. Many of elements are not addressed in the file provided nor could they be found in policy. See corrective action for specific elements needing addressed.

**Corrective actions:** 115.252(1) Develop and implement policy/procedure to address elements:

(d.1) Computation of the 90-day time period shall not include time consumed by residents in preparing any administrative appeal.

(d.2) The agency may claim an extension of time to respond, of up to 70 days, if the normal time period for response is insufficient to make an appropriate decision. The agency shall notify the resident in writing of any such extension and provide a date by which a decision will be made.

(d.3) 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, the resident may consider the absence of a response to be a denial at that level.

(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, and 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. Provide this information to residents & If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision. While address in policy, there is no indication of this information being provided to the residents.

(f) The initial response and final agency decision shall document the agency's determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance.

(g) The agency may discipline a resident for filing a grievance related to alleged sexual abuse only where the agency demonstrates that the resident filed the grievance in bad faith.

**Action taken:** Element (e) above is addressed in current policy therefore does not need further action to meet the standard.

**Final findings:** Elements (d.2), (d.3, (f) and (g) had no noted actions taken during the corrective action period. Therefore, the initial findings of not meeting the standard applies.

## Standard 115.253: Resident access to outside confidential support services

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

#### 115.253 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations?  Yes  No
- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible?  Yes  No

#### 115.253 (b)

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

#### 115.253 (c)

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

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

**Policy:** Policy does not address.

**Other documentation:** MOU with the Rape Crisis Center.

Poster with RCC phones numbers and address.

Email discussion with RCC PREA coordinator indicating all services in MOU are free of charge to the residents.

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

**Initial findings:** Does not meet standard. No evidence of information provided to residents on the extent to which such communications as addressed in element (a) of this standard will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

**Corrective actions:** 115.253--Provide verification that the facility informs residents, prior to giving them access to outside victim advocates for emotional support services related to sexual abuse, 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.

**Action taken:** ARC provided the auditor with an MOU with the Rape Crisis Center who agrees to:  
provide and staff a 24 hour sexual assault and sexual harassment hotline number for all ARC residents and to report allegations to the CSCD;  
provide posters, flyers and contact cards with the information to residents;  
provide ARC staff relative training;  
obtain the resident's consent prior to contacting CSCD or other parties to report an incident of sexual violence;  
provide a victim advocate for any all aspects of the incident including SANE;  
provide crisis interventions as needed;

provide referrals to crisis centers or other agencies after release of transfer;  
maintain confidentiality as required;  
respond to written communication from residents;  
follow state and federal mandates to report any abuse or suspected abuse of a minor, person over the age of 64 or person with a disability to the appropriate authorities;  
ARC agrees to respect the confidentiality between resident and advocate;  
Communicate to residents the availability of confidential support

**Final findings:** With the above action taken the agency/facility now meet all elements of this standards.

## Standard 115.254: Third-party reporting

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

### 115.254 (a)

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment?  Yes  No
- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident?  Yes  No

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

**Policy:** No policy in file.

**Other documentation:** MOU with RCC.

**Interviews and observations:** Most random residents did not understand third party reporting. Most staff were aware of the third-party reporting option for residents.

**Findings:** Originally the facility was found non-compliant. Third party reporting is found in policy and residents are made aware of third-party reporting. No documentation was provided to indicate the information is distributed publicly. Upon review of the action taken by the facility, it now meets this standard.

**Corrective Action:** 115.254--Post publicly (website or other) how to report sexual abuse and sexual harassment on behalf of a resident. The agency/facility is referred to the PREA Resource Center FAQs on 115.54.

**Action taken:** Auditor was directed to website-- <https://www.bexar.org/2969/Prison-Rape-Elimination-Act-PREA>. Website discussed zero tolerance policy and methods for third party's to report sexual abuse at Applewhite Recovery Center.

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

## OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

### Standard 115.261: Staff and agency reporting duties

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

#### 115.261 (a)

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

#### 115.261 (b)

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

### 115.261 (c)

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

### 115.261 (d)

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

### 115.261 (e)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

**Policy:** ARC SOP 4.39 states: The ARC requires 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; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

Apart from reporting to designated supervisors or officials, staff shall not reveal any information related to a sexual abuse or sexual harassment report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions.

Unless otherwise precluded by Federal, State, or local law, medical and mental health practitioners shall be required to report sexual abuse and to inform residents of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services.

The facility staff shall report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated PREA Coordinators or the Assistant Chief for Residential Services.

**Other documentation:**

**Interviews and observations:** Interviews with medical staff indicate are required to report any incident of sexual abuse and are required to inform residents of staff duty to report and limitations of confidentiality. Random staff interviewed stated they were required to report any incident of abuse, harassment, retaliation or staff neglect. Staff were also aware they were not to discuss incidents with anyone other than supervisors or investigators. All allegations are referred to the facility director or PREA coordinator who report all allegations to either facility investigators or local law enforcement.

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

## Standard 115.262: Agency protection duties

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

#### 115.262 (a)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

**Policy:** ARC SOP 4.39 states: When a staff member learns that a resident is subject to a substantial risk of imminent sexual abuse, he/she shall take immediate action to protect the resident. Similarly, upon receipt of allegations of sexual harassment, the staff member shall take immediate action to protect the resident(s) at risk for harassment.

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

**Findings:** Based on the above 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

*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:** ARC SOP states: Upon receiving an allegation that a resident was sexually abused while confined at another facility, the PREA Coordinator or Assistant Chief of Residential Services shall notify the head of the other facility or appropriate office of the agency where the alleged abuse occurred as soon as possible, but no later than 72 hours after receiving the allegation. Where criminal conduct is alleged, the Bexar County Sheriff's Department shall be notified.

**Other documentation:** Example of this facility receiving an allegation of sexual abuse at another facility.

**Interviews and observations:** In interviews with the PREA Coordinator and the Facility Director, notification has and would be made and follow up would occur. All incidents or allegations are documented. The one example meets the standard except as noted in findings below.

**Findings:** The facility does not meet the standard. While policy and practice are in place, (from PREA Resource Center FAQs) the notification must be made from the facility head, or appear to a third party to have originated with the facility head. For example, the facility head could instruct his or her administrative assistant to send the notification on the facility head's letterhead and with the facility head's signature, or to send the notification from the facility head's email address. By contrast, the facility's PREA Compliance Manager could not send the notification from his or her email address and merely copy the facility head.

**Corrective action:** 115.263--Adjust wording in policy to reflect the notification is made by the facility head or at the direction of the facility head as outlined in the PREA Resource Center FAQs.

**Action taken:** No noted actions taken during the CAP.

**Final findings:** From the PREA Resource Center FAQs: The notification must, at a minimum, be: (1) Made at the direction of the facility head, and (2) Appear to a third party to have originated with the facility head. For example, the facility head could instruct his or her administrative assistant to send the notification on the facility head's letterhead and with the facility head's signature, or to send the notification from the facility head's email address. By contrast, the facility's PREA Compliance Manager could not send the notification from his or her email address and merely copy the facility head.

The facility does not meet the standard as policy directs the PREA Coordinator to make the contact with no indication that this was to be accomplished at the direction of the facility head or that the facility head actually makes the contact.

## Standard 115.264: Staff first responder duties

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

#### 115.264 (a)

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

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

#### 115.264 (b)

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

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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

**Policy:** ARC SOP 4.39 states: Upon learning of an allegation that a resident was sexually abuse, the staff member responding to the report shall be required to:  
 Take only basic information utilizing the following script;  
 I must notify the facility administration immediately so you do not have to give me specific details other than some basic information I need to obtain.  
 Do you need medical attention?  
 Who abused you?  
 When did this happen?  
 Where did the abuse happen?  
 I'm going to place you in a separate room for your safety.

Separate the victim and perpetrator, rendering aid if needed. The alleged perpetrator shall be subject to heightened monitoring or isolated depending on the allegation and the imminent threat to the victim or other residents;

In cases of alleged sexual assault (rape), call 911. In all cases of alleged sexual abuse notify the PREA Coordinator or Assistant Chief of Residential Services.

Secure the scene protecting potential evidence from being tampered with until Law Enforcement or the PREA Coordinator arrives. If the alleged abuse occurred within a time period that still allows for the collection of physical evidence, as determined by the PREA Coordinator, Staff will request that neither the alleged victim nor alleged perpetrator take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating.

The Staff will document their actions and basic information obtained immediately following the aforementioned steps and before the end of their shift.

The Staff will not start their own investigation or ask for statements.

The Staff will not discuss the matter with any other employee other than the initial report to the PREA Coordinator or Assistant Chief of Residential Services and the assigned investigator to the case.

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

**Findings:** Based on policy as written and interviews with random staff and first responders, the facility meets the elements of this standard. Recommend first responder cards be carried by all assigned security staff. Auditor recommends changing that the alleged abuser be “requested” to not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating to: “ensure” the alleged abuser be not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. (request of alleged victim, ensure alleged abuser)

## 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.*

**Initial findings:** Does not meet standard. The facility has not developed a coordinated response plan.

**Corrective action:** 115.265--MIOF needs to develop and institute a facility specific coordinated response plan as defined in this standard. 115.265 states: "The facility shall develop a written institutional plan to coordinate actions taken in response to an incident of sexual abuse, among staff first responders, medical and mental health practitioners, investigators, and facility leadership."

**Action taken:** No noted actions were taken to address this standard.

**Final finding:** The facility has not provided a facility specific coordinated response plan therefore does not meet the standard.

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

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

#### 115.266 (a)

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

#### 115.266 (b)

- Auditor is not required to audit this provision.

### Auditor Overall Compliance Determination

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

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

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

### Instructions for Overall Compliance Determination Narrative

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

**Interviews and observations:** Per an interview with the agency head and PREA coordinator, the facility does not engage in collective bargaining or other agreements that could limit the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted.

**Findings:** Facility meets this standard.

## Standard 115.267: Agency protection against retaliation

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

#### 115.267 (a)

- Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff?  Yes  No
- Has the agency designated which staff members or departments are charged with monitoring retaliation?  Yes  No

#### 115.267 (b)

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

#### 115.267 (c)

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

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor any resident disciplinary reports?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident housing changes?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident program changes?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor negative performance reviews of staff?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor reassignments of staff?  Yes  No
- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need?  Yes  No

#### 115.267 (d)

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

#### 115.267 (e)

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

#### 115.267 (f)

- Auditor is not required to audit this provision.

#### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

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

### Instructions for Overall Compliance Determination Narrative

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

**Policy:** ARC SOP 4.39 addresses the elements of this standard with verbiage from the standard itself.

**Interviews and observations:** In interviewing the PREA coordinator, who is the staff charged with monitoring for retaliation, should the need occur, he would follow the policy. Auditor recommends a checklist specific to retaliation monitoring to ensure all elements are addressed.

**Findings:** Based on the above policy 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

*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:** ARC SOP 4.39 states:

A. General Investigation Policy: Except for those cases referred for criminal investigation, the ARC shall conduct investigations of all allegations of sexual abuse, sexual harassment and, or retaliation in a prompt, thorough, and objective manner, including third-party and anonymous reports. Complaints of sexual assault (rape) shall not be investigated by the ARC, but immediately reported to the Bexar County Sheriff's Department as provided by First Responder protocol. The PREA Coordinator will monitor and ensure that sexual abuse criminal investigations referred to law enforcement are timely addressed and investigated.

#### B. 2. Investigations

- a. Administrative or criminal investigations shall be completed for all allegations of sexual abuse, sexual harassment, retaliation and, or allegations of staff neglect or violation of responsibilities that may have contributed to incidents of sexual abuse, sexual harassment and, or retaliation.
- b. Allegations of sexual abuse involving allegations of sexual assault (rape) shall be referred to the Bexar County Sheriff's Department for investigation.
- c. The PREA Coordinator shall coordinate the investigation of complaints, logging assignment of the investigation and tracking completion of the investigation stages.
- d. Investigators shall gather and preserve evidence, including, but not limited to, videotapes, logs, emails and other written documents pertinent to the allegations. Investigators shall interview the complainant, alleged perpetrator and named and potential witnesses, utilizing a tape recorder to document all testimony.
- e. Investigators shall log all interactions and evidence collected, identifying the nature and date of the interaction and, or evidence collected.
- f. Investigators shall utilize Garrity Warnings when interviewing staff alleged to have engaged in acts of sexual abuse (other than sexual assault), sexual harassment or retaliation rising to the level of violations of the State official oppression statute where applicable.
- g. After a prompt thorough, and objective investigation of the facts, Investigators shall prepare an investigation report in all cases. A finding shall be made based upon a preponderance of the evidence standard. The report should document the allegations, evidence and testimony, analysis of the evidence gathered, credibility assessments of parties and witnesses, and findings. Findings should be determined to be "unfounded," "unsubstantiated," or "substantiated." Investigators shall also make an effort to determine if staff actions or failures contributed to substantiated findings.

**Other documentation:** Facility investigator FBI training certificate for managing and conducting interval affairs investigation.

Facility investigator certificates for completion of NIC's PREA Coordinator's Roles and Responsibilities and PREA: Investigating Sexual Abuse in a Confinement Facility.

**Interviews and observations:** Interview with the assigned administrative investigator, who investigates for all three programs, indicates he has been training and is very knowledgeable or the investigative process.

**Initial findings:** Does not meet standard. Elements (i) and (j) are not addressed in policy.

**Corrective action:** 115.271--The facility needs to adjust policy to reflect (i) the agency retains 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; and (j) the agency ensures 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.

**Action taken:** While the auditor inadvertently marked this standard and all elements above as being compliant, a corrective action was issued to address elements (i) and (j). Upon further review and evaluation of interviews conducted with the facility head and investigator, an investigation would continue to completion regardless of the status of the alleged victim or alleged abuser and all documents are maintained for at least five years after an alleged abuser is released/transferred or no longer employed.

**Final findings:** While the agency/facility are shown as meeting the standard, policy should be updated to reflect current practice.

## Standard 115.272: Evidentiary standard for administrative investigations

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

#### 115.272 (a)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

#### **Policy:** ARC SOP 4.39 states:

After a prompt thorough, and objective investigation of the facts, Investigators shall prepare an investigation report in all cases. A finding shall be made based upon a preponderance of the evidence standard. The report should document the allegations, evidence and testimony, analysis of the evidence gathered, credibility assessments of parties and witnesses, and findings. Findings should be determined to be "unfounded," "unsubstantiated," or "substantiated." Investigators shall also make an effort to determine if staff actions or failures contributed to substantiated findings.

Interviews and observations:

**Interviews and observations:** In interviewing the assigned investigator, he was aware of this standard and requirements

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

## Standard 115.273: Reporting to residents

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

#### 115.273 (a)

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

#### 115.273 (b)

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

#### 115.273 (c)

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

#### 115.273 (d)

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

#### 115.273 (e)

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

### 115.273 (f)

- Auditor is not required to audit this provision.

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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

**Policy:** ARC SOP 4.39 states:

#### 3. Notification to the Resident

- a. Any resident who makes a complaint of sexual abuse shall be informed by the PREA Coordinator, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following investigation of the matter.
- b. Following a resident's allegation that a staff member has committed sexual abuse against the resident, the PREA Coordinator shall inform the resident (unless the matter is determined to have been unfounded) whenever:
  1. The staff member is no longer posted within the resident's unit;
  2. The staff member is no longer employed at the facility;
  3. The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or,
  4. The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility.
- c. Following a resident's allegation that he or she has been sexually abused by another resident in an agency facility, the PREA Coordinator shall subsequently inform the alleged resident victim whenever: the agency learns that the alleged abuse has been indicted on a charge related to sexual abuse within the facility; or the agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility.

**Interviews and observations:** Interviews with the PREA Coordinator and facility head, both stated this would happen per policy.

**Initial findings:** The facility reports investigations did occur and a resident was notified, but no documentary evidence indicates the facility made notifications to the residents as outlined in the standard.

**Corrective action:** 115.273—Provide examples documentation of notifications being made to residents as outlined in the elements of this standard.

**Action taken:** While the auditor inadvertently checked the “yes” box on element (e) the corrective action was provided to the facility. No noted action was taken. The auditor did not receive verification of documentation that residents are informed as required by the standard, however, this standard applies specifically to sexual abuse and, upon review of cases and the annual report, no sexual abuse cases were reported within the last 12 months.

**Final findings:** Upon further review and discussions with the facility, no sexual abuse cases were alleged requiring the facility to notify the resident of the status of the case. Policy does address the standard. The facility meets the elements of this standard.

## DISCIPLINE

### Standard 115.276: Disciplinary sanctions for staff

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

#### 115.276 (a)

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

#### 115.276 (b)

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

#### 115.276 (c)

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

#### 115.276 (d)

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

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

**Policy:** ARC SOP 4.1 states: Employees found to have engaged in sexual abuse, sexual harassment or other violations of PREA Standards will be subject to disciplinary action up to and including termination as provided by Bexar County CSCD Administrative Policy 1.21., and, or criminal prosecution where applicable.

### Other documentation:

**Interviews and observations:** Interviews with the agency head, facility head and human resources staff confirmed the policy would be followed should the need arise.

**Initial findings:** The facility does not meet the standard as elements (b), (c) & (d) are not addressed.

**Corrective action:** 115.276-The facility needs to address, in policy, element (b): termination is the presumptive disciplinary sanction for staff who have engaged in sexual abuse (c): 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; and element (d): 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.

**Action taken:** No noted actions were taken.

**Final findings:** With no action taken or provided to the auditor, the initial findings of not meeting standard applies.

## Standard 115.277: Corrective action for contractors and volunteers

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

#### 115.277 (a)

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

#### 115.277 (b)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

**Policy:** ARC SOP 4.1 states: Volunteers or contractors found to have engaged in sexual abuse or sexual harassment will be barred from the facility, reported to relevant licensing bodies and, or reported to law enforcement where applicable.

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

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

## **Standard 115.278: Interventions and disciplinary sanctions for residents**

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

#### **115.278 (a)**

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

#### **115.278 (b)**

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

#### **115.278 (c)**

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

#### **115.278 (d)**

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

#### **115.278 (e)**

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

#### **115.278 (f)**

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

#### **115.278 (g)**

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

**Policy:** ARC SOP 4.1 states: Residents found to have engaged in sexual abuse, sexual harassment or other violations of PREA Standards are subject to disciplinary sanctions up to and including submission of a violation report to the supervising court, immediate removal from the facility and, or reported to law enforcement where applicable.

**Other documentation:** Disciplinary sanctions grid.

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

**Initial findings:** Facility does not meet the standard. Provided policy and documents in the file do not address elements: (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; (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; (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; (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; and (g) Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse.

**Corrective actions:** 115.78--Facility policy needs address elements (c) through (g) of this standard. From the standard: (c) The disciplinary process shall consider whether a resident's mental disabilities

or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed.

(d) 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 offending resident to participate in such interventions as a condition of access to programming or other benefits.

(e) The agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact.

(f) For the purpose of disciplinary action, 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.

(g) An agency may, in its discretion, prohibit all sexual activity between residents and may discipline residents for such activity. An agency may not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced.

**Action taken:** In interviews with the PREA Coordinator, any confirmed incident of sexual abuse would result in the abuser being removed from the program and would face disciplinary action through the sentencing agency, not ARC or MIOF. The facility does not offer therapy to address the underlying issues as the abuser would be removed from the facility. Sanctions for sexual abuse would be administered by the sentencing agency.

**Final findings:** The facility meets the elements of this standard. The auditor recommends updating policy to reflect the current practices.

## 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:** No policy provided in file.

**Other documentation:** MOU with rape crisis center. In the MOU RCC agrees to: to provide crisis intervention services to any resident who has been affected by sexual assault or harassment; offer support, coping strategies, information and referrals; provide residents with referrals for treatment at local rape crisis centers or other social service agencies after release; etc...

**Interviews and observations:** Facility policy nor MOU addresses emergent medical care or element (c) above. Medical services on-site are 1<sup>st</sup> aid and immediate care only. All medical care beyond that is conducted off-site.

**Initial findings:** ARC does not meet this standard as no documentation indicates what agency has a means to provide emergency medical services. There is no on-site medical provider for this purpose and no agreement with local medical providers. No documentation of the facility or agency offering timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate.

**Corrective actions:** 115.282--(1) Develop and implement an MOU with local medical agency or organization to provide (at no cost to resident) resident victims of sexual abuse with timely, unimpeded

access to emergency medical treatment as outlined in this standard and standard 115.283. Attempts to enter into the agreements, whether accomplished or not, are to be provided to the auditor. (2) Add element (c) of the standard to the policy and to the noted MOU.

**Action taken:** No action was taken or provided to the auditor.

**Final findings:** While the auditor called for an MOU or agreement with a local medical agency to provide unimpeded access to emergency medical treatment, an MOU or agreement is a best practice and not necessary required to meet the standard. However, some type of policy or plan needs to be in place to provide services as outlined in the standard. Making this part of the Coordinated Response Plan may be sufficient. ARC has not identified who would provide such services and does not have a Coordinated Response Plan. ARC has MOUs with the RCC for crisis intervention and Methodist Healthcare System of San Antonio LTD. LLP for SANE therefore an agreement or MOU would be consistent with current practice. Nothing was provided to the auditor to indicate an agreement to provide emergency or ongoing medical/mental health care for sexual abuse victims and abusers. Additionally, no information was provided to indicate who or where information will be provided to victims of sexual abuse about emergency contraception or SDT evaluation and treatment.

### **Standard 115.283: Ongoing medical and mental health care for sexual abuse victims and abusers**

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

##### **115.283 (a)**

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

##### **115.283 (b)**

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

##### **115.283 (c)**

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

##### **115.283 (d)**

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

##### **115.283 (e)**

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

#### 115.283 (f)

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

#### 115.283 (g)

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

#### 115.283 (h)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

**Other documentation:** MOU with rape crisis center. In the MOU RCC agrees to: to provide crisis intervention services to any resident who has been affected by sexual assault or harassment; offer support, coping strategies, information and referrals; provide residents with referrals for treatment at local rape crisis centers or other social service agencies after release; etc...

**Initial findings:** The facility does not meet the elements of this standard as no information was provided in the file to address. The RCC MOU addresses crisis intervention and follow up services for the intervention, and offers support, coping strategies, information and referrals.

There is nothing provided to address providing 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; 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; offering pregnancy tests to resident victims of sexually abusive vaginal penetration while incarcerated; 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; resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate; the facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners.

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

Offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility; to include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody;

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

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

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

Attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners.

**Action taken:** No noted actions taken or provided to the auditor.

**Final findings:** As no actions were taken to address the standard or the corrective action above, the initial finds of not meeting the standard apply.

## DATA COLLECTION AND REVIEW

### Standard 115.286: Sexual abuse incident reviews

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

#### 115.286 (a)

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

#### 115.286 (b)

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

#### 115.286 (c)

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

#### 115.286 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse?  Yes  No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility?  Yes  No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse?  Yes  No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts?  Yes  No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff?  Yes  No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.286(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager?  Yes  No

#### 115.286 (e)

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

#### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

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

### Instructions for Overall Compliance Determination Narrative

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

**Policy:** None in file

**Other documentation:** Investigative report

**Interviews and observations:** In an interview with the PREA Coordinator, the facility has not had need to conduct an incident review and has not yet developed a system for incident reviews.

**Initial findings:** The facility does not meet this standard as they have no policy to address and no system in place to conduct an incident review.

**Corrective actions:** 115.286--MIOF needs to address this standard in full.

(a) The facility shall 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.

(b) Such review shall ordinarily occur within 30 days of the conclusion of the investigation.

(c) The review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners.

(d) 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; lesbian, gay, bisexual, transgender, or intersex 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; and

(6) Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement, and submit such report to the facility head and PREA compliance manager.

(e) The facility shall implement the recommendations for improvement or shall document its reasons for not doing so.

In discussions with the auditor, the facility will develop policy to address this standard. Policy adjust will be forwarded to the auditor. The auditor strongly recommends the development of an "Incident Review Checklist" to fully address each element of the standard when needed.

**Action taken:** No noted actions were taken or provided to the auditor.

**Final findings:** With no actions taken or provided to the auditor, the initial findings of not meeting the standard applies.

## 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:** none in file

**Initial findings:** The facility does not meet this standard as they have no policy to address and no documentation to support compliance.

**Corrective actions:** 115.287—The agency/facility needs to address this standard in full.

(a) The agency shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions.

(b) The agency shall aggregate the incident-based sexual abuse data at least annually.

(c) The incident-based data collected shall 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.

(d) The agency shall maintain, review, and collect data as needed from all available incident-based documents including reports, investigation files, and sexual abuse incident reviews.

(e) The agency also shall obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents.

(f) Upon request, the agency shall provide all such data from the previous calendar year to the Department of Justice no later than June 30.

**Action taken:** The agency/facility provided the Applewhite Recovery Center PREA Annual Report for 2019. As the agency was not completing annual reports, this will address the standard.

**Final findings:** Based on the actions noted above with the agency/facility providing the 2019 annual report, the agency meets 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:** Policy provided does not address the elements of this standard.

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

**Corrective actions:** 115.288-- The agency/facility needs to address this standard in full.

- (a) The agency shall 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:
- (1) Identifying problem areas;
  - (2) Taking corrective action on an ongoing basis; and
  - (3) Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole.
- (b) Such report shall include a comparison of the current year's data and corrective actions with those from prior years and shall provide an assessment of the agency's progress in addressing sexual abuse.
- (c) The agency's report shall be 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.
- (d) The agency may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility, but must indicate the nature of the material redacted.

**Action taken:** The agency/facility provide the Applewhite Recovery Center PREA Annual Report for 2019. As the agency was not completing annual reports, this will address the standard.

**Final findings:** Based on the actions noted above with the agency/facility providing the 2019 annual report, the agency meets this standard. As this is the first year of their annual report, no comparison can be made.

## Standard 115.289: Data storage, publication, and destruction

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

#### 115.289 (a)

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

#### 115.289 (b)

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

#### 115.289 (c)

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

#### 115.289 (d)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

**Policy:** Nothing in file.

**Initial findings:** The facility does not meet the standard.

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

(a) The agency shall ensure that data collected pursuant to § 115.287 are securely retained.

(b) The agency shall 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.

(c) Before making aggregated sexual abuse data publicly available, the agency shall remove all personal identifiers.

(d) The agency shall 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.

**Action taken:** No noted action taken or provided to the auditor, specific to this standard.

**Final findings:** With no actions taken or provided to the auditor, the initial findings of not meeting the standard applies.

## AUDITING AND CORRECTIVE ACTION

### Standard 115.401: Frequency and scope of audits

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

##### 115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*)  Yes  No

##### 115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard.*)  Yes  No
- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.)  Yes  No  NA
- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.)  Yes  No  NA

##### 115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility?  Yes  No

##### 115.401 (i)

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

##### 115.401 (m)

- Was the auditor permitted to conduct private interviews with inmates, residents, and detainees?  Yes  No

##### 115.401 (n)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

Initial audit.

## Standard 115.403: Audit contents and findings

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

#### 115.403 (f)

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

### Auditor Overall Compliance Determination

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

## Instructions for Overall Compliance Determination Narrative

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

Initial audit.

## 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.<sup>1</sup> Auditors are not permitted to submit audit reports that have been scanned.<sup>2</sup> See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Dave Cotten

November 12, 2019

**Auditor Signature**

**Date**

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

<sup>2</sup> See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.