PREA AUDIT REPORT ☐ Interim ☒ Final

COMMUNITY CONFINEMENT FACILITIES

Date of report: 07-14-2017

Auditor Information			
Auditor name: David "Will" Weir			
Address: P. O. Box 1473; Raton, NM 87740			
Email: will@preaamerica.com			
Telephone number: 405-945-1951			
Date of facility visit: 02-17-2017			
Facility Information			
Facility name: Amarillo Transitional Treatment Center (ATTC), also known as Plainview Serenity Center, Inc.			
Facility physical address: 9300 SE 3rd Ave.; Amarillo TX 79118			
Facility mailing address: *(if different from above)* PO Box 278; Plainview TX 79073-0278			
Facility telephone number: 806-293-9722			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☒ Private not for profit		
Facility type:	☐ Community treatment center ☐ Halfway house ☒ Alcohol or drug rehabilitation center	☐ Community-based confinement facility ☐ Mental health facility ☐ Other	
Name of facility's Chief Executive Officer: Paul Walker			
Number of staff assigned to the facility in the last 12 months: 23			
Designed facility capacity: 59			
Current population of facility: 52			
Facility security levels/inmate custody levels: non-secure supportive residential			
Age range of the population: 18-100			
Name of PREA Compliance Manager: Paul Walker		**Title:** CEO	
Email address: rs-admin@nts-online.net		**Telephone number:** 806-293-9722 x303	
Agency Information			
Name of agency: Plainview Serenity Center, Inc. dba Amarillo Transitional Treatment Center (ATTC)			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: Click here to enter text.			
Mailing address: *(if different from above)* PO Box 278; Plainview TX 79073-0278			
Telephone number: 806-398-9115			
Agency Chief Executive Officer			
Name: Paul Walker		**Title:** CEO	
Email address: rs-admin@nts-online.net		**Telephone number:** 806-293-9722 x303	
Agency-Wide PREA Coordinator			
Name: Paul Walker		**Title:** CEO	
Email address: rs-admin@nts-online.net		**Telephone number:** 806-293-9722 x303	

AUDITFINDINGS

NARRATIVE

On December 26, 2016 PREAamerica LLC was secured to conduct the PREA Audit for Plainview Serenity Center, Inc. dba Amarillo Transitional Treatment Center (ATTC) by CEO Paul Walker. The audit team received verification that audit notices were posted at the facility by December 29. Mr. Walker was provided a link to the PREA Resource Center webpage and Pre-Audit Questionnaire (PAQ) and encouraged to submit all materials before the end of January. Some documentation was received, but not the PAQ, so the audit team sent email reminders such as, "We encourage sending the documentation before the visit so we can clear up any issues before we arrive." A PAQ was received without all the supportive documentation required and with answers and information indicating possible PREA compliance issues. Some answers on the PAQ did not match the PREA policy provided. The PREA Resource Center's "PREA Compliance Audit Instrument Checklist of Policies/Procedures and Other Documents" was sent and a phone conference was held offering suggestions and encouragement, along with a list of topics for clarification.

The arrival of the audit team on 02-17-2017 appeared to be a surprise to the staff working at the facility when the team arrived as scheduled. Nevertheless, the audit team met with Facility Director Kurt Billups when he arrived and participated in a facility tour, assisted by Direct Care Staff Antonio Graves. The audit team started random interviews using outdated lists that were provided. Five female residents and seven male residents were interviewed. Also, the team interviewed all eight available staff. Some of these staff initially said they had not heard of PREA, but seemed to have vague recollections after prompts. They seem open to learning more and seem to welcome these policies and indicate these policies and procedures are consistent with what they do. Additional staff interviews were part of the Corrective Action Plan (CAP). CEO Paul Walker arrived from the Plainview office in the afternoon to assist. He had been working on updating written policies. PREA policy updates and revisions had been made and were provided to the audit team.

The exit conference consisted of the audit team and Mr. Walker and Texas Department of Criminal Justice (TDCJ) Deputy Director of Programs Stephen Fox also participating by conference call. The exit conference established that the facility was passing very few standards, but had strengths to build on. Mr. Walker immediately began addressing the audit team's concerns and sent email updates during the following weeks. Also, the audit team had numerous phone conferences with him. Considerable progress was made, but a CAP was still needed to assure changes were properly verified and institutionalized in the facility culture. Strengths to build on included the residents already having a good knowledge of PREA before arriving at the facility, ATTC written policy changes already being made and approved prior to the onsite audit, and full institutional compliance with search and cross gender supervision standards. Basically, the facility does not do personal searches and opposite gender staff rarely enter areas where residents are changing clothes, showering, etc., yet they are dependable to announce their presence. Also, the facility culture already had an institutionalized expectation of safety. Staff and residents indicate a belief that residents will be kept safe and any violations will be addressed. During the days and weeks immediately after the onsite audit, compliance was verified regarding background checks and staffing plans being done. Despite documentation not being provided until after the onsite audit, those standards seem to have been in place a full 12 months so were not included in the CAP. Also, a strength for the facility is ongoing TDCJ contract monitoring involvement. TDCJ professionals are available to assist the facility in various ways, and continued this activity throughout the CAP process.

The Corrective Action Plan included the following standards: 211, 221, 222, 231, 234, 241, 242, 261, 264, 265, 267, 271, 272, 273, 276, 288, and 289.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Amarillo Transitional Treatment Center (ATTC) compound consists of former residences and buildings that previously belonged to a local family. These buildings have been converted to the current configuration. One building serves as the administrative offices which has four offices, a restroom and a conference area. This building also contains an overflow dorm for clients and a bathroom for them. At the time of the audit it was used for adult male housing but may also be used for adult females depending on the composition of the population. There is an outbuilding not used by clients located behind the administrative building.

A cafeteria building has a large dining area with tables, sometimes used for visitation. The restrooms are in the back and the kitchen, which is off to the side, has a large window into the eating area. There are locked storage areas as well.

The women's dorm is across from the cafeteria building. Its main entry is next to the dorm's dining and kitchen area, with a bathroom. The living room opens into the dining room, which has a separate exit and two bedroom areas. Each bedroom has multiple beds with bathrooms.

The men's building is across from the women's dorm and next to the cafeteria building. It has two levels. The upper level has a vestibule which opens to the living room and kitchen area. This is a large room for day time activities. The cross shaped floor plan has a bedroom with several beds and bathroom on the left and a smaller bedroom and bath on the right, along with an office for staff. At the far end is a balcony. The lower level has stairs coming down to the "family room" at one end is a lower balcony at the other a utility room and office. Either side has bedrooms with multiple beds and bathrooms.

SUMMARY OF AUDIT FINDINGS

The Amarillo Transitional Treatment Center (ATTC) received their on-site Prison Rape Elimination Act (PREA) Audit on February 17, 2017 by DOJ certified PREA Auditor Will Weir of PREA America LLC. The auditor used the PREA Standards for Community Confinement Facilities and was able to verify the facility's compliance with the standards in 21 applicable areas during the audit and in the 30 days after the audit. There were 17 areas where verification of compliance was still pending when the Interim Report was issued to the facility on 03-21-2017. These areas were addressed in the Corrective Action Plan (CAP). In addition to demonstrating compliance with the 17 areas listed in the CAP, the facility was expected to maintain compliance in the 21 areas already verified. The facility successfully verified compliance with all applicable standards, prompting the issuance of this Final Report.

Number of standards exceeded: 0

Number of standards met: 39

Number of standards not met: 0

Number of standards not applicable: 1

Standard 115.211 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Amarillo Transitional Treatment Center (ATTC), also known as Plainview Serenity Center, Inc., has written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment and outlining the agency's approach to preventing, detecting, and responding to such conduct. However, during the pre-audit and onsite audit process, it could not be verified whether the facility had all their PREA policies in practice. Additionally, the facility/agency is required to employ an upper-level PREA Coordinator with sufficient time and authority to develop, implement, and oversee efforts to comply with the PREA standards. At the time of onsite audit, the Organizational Chart being used by the facility and supplied to the audit team did not include a PREA Coordinator. The PREA Coordinator listed on the Pre-Audit Questionnaire (PAQ), Kurt Billups, did not know he was the PREA Coordinator and indicated he was not very familiar with PREA. The PAQ had been completed by CEO Paul Walker. Immediately after the onsite audit the audit team was notified that the CEO, Paul Walker, was taking the reins as the PREA Coordinator. An alternative Organizational Chart was provided after the 02-17-2017 onsite audit showing that Mr. Walker is the PREA Coordinator. This particular Organizational Chart was dated 06-20-2016. Yet the latest version of policy is not consistent with this particular Organizational Chart. Policy states, on page 1, the "Program Supervisor at ATTC will be the designated PREA Coordinator." This standard was on the corrective action plan because the facility had not verified that it had consistent or effective PREA leadership. The audit team was also concerned that the organization may have difficulty getting written policies and organizational charts communicated from the Plainview office and into actual practice in Amarillo.

Corrective Action Plan (CAP): These issues were resolved during the CAP. CEO Walker continued to be the PREA Coordinator throughout the CAP period, and this was reflected in the Organizational Chart which was distributed to staff along with policy updates and reviews. Mr. Walker hired and trained a new Director of Operations, Melissa Lanford, who is in the process of becoming the new PREA Coordinator. Mr. Walker and Ms. Lanford were both interviewed by the audit team and found to be informed regarding their PREA duties.

Standard 115.212 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

N/A. ATTC takes residents from TDCJ, through a contractual agreement, but does not contract out for the confinement of its residents. TDCJ requires PREA compliance.

Standard 115.213 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

ATTC has developed and documented a staffing plan that provides for adequate levels of staffing to protect residents against sexual abuse. This plan considers the physical layout of the facility, the composition of the resident population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse; and any other relevant factors. At least annually the facility reviews the staffing plan to see whether adjustments are needed in the staffing plan, prevailing staffing patterns, the deployment of video monitoring systems and other monitoring technologies, or the allocation of facility/agency resources to commit to the staffing plan to ensure compliance with the staffing plan. The staffing plan was provided to the auditor for review. No staff or inmate interviews indicated any incidents of staffing plan deviations, or times when the facility was not adequately staffed. There is documentation of the staffing plan being reviewed. However, in circumstances where the staffing plan is not complied with, policy requires the facility to document and justify all deviations from the plan. The average daily number of residents is 55. The average daily number of residents on which the staffing plan was predicated is 59.

Standard 115.215 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility does not conduct strip searches, visual body cavity searches, or pat searches. If an emergency indicated a search was required, the police would be called and it would be documented. Interviews indicate this policy is being followed. The facility has implemented policies and procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine checks (this includes viewing via video camera). Policies and procedures require staff of the opposite gender to announce their presence when entering a resident housing unit, and interviews indicate this policy is being followed.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency has established procedures to provide disabled residents, and residents with limited English proficiency, 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. Policy prohibits use of 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. The agency or facility documents the limited circumstances in individual cases where resident interpreters, readers, or other types of resident assistants are used. In the past 12 months, there have been no instances where resident interpreters, readers, or other types of resident assistants have been used. The onsite audit interviews confirmed that all residents can participate fully, with no exceptions found.

Standard 115.217 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

ATTC policy prohibits hiring or promoting anyone who may have contact with residents and prohibits enlisting the 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); 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 has been civilly or administratively adjudicated to have engaged in any of this activity. Agency policy requires the consideration of 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. Policy requires that before it hires any new employees who may have contact with residents, it conducts criminal background record checks; and, consistent with federal, state, and local law, makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. Policy requires that a criminal background record check be completed before enlisting the services of any contractor who may have contact with residents. The PREA standard requires that background record checks be conducted at least every five years. Policy clearly states that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination. Policy also clearly states that all applicants and employees who may have contact with residents will be asked 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. All interviews with administrators involved in hiring confirm these policies are being followed. The agency also imposes upon employees a continuing affirmative duty to disclose any such misconduct. Policy also clearly states that 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. Several personnel files were randomly pulled, verifying current background checks have been performed.

Standard 115.218 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The agency/facility has not acquired a new facility or made a substantial expansion or modification to existing facilities since August 20, 2012. However, the facility has updated their video surveillance system considering PREA.

Standard 115.221 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

ATTC is responsible for making sure administrative and criminal sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct) are conducted appropriately at the facility. All residents who experience sexual abuse are to have access to forensic medical examinations at an outside facility without financial cost to the victim. Where possible, examinations are conducted by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs). SANE's and advocates are available through Northwest Texas Healthcare System, but when SANEs or SAFEs are not available, a qualified medical practitioner performs forensic medical examinations. The facility is required to document efforts to provide SANEs or SAFEs. In the past 12 months, there have been no forensic medical exams conducted because there were no abuse allegations. The facility is required to attempt to make a victim advocate from a rape crisis center available to the victim, either in person or by other means and these efforts are to be documented. When a rape crisis center is not available to provide victim advocate services, the facility is to provide a qualified staff member from a community-based organization or a qualified agency staff member. If requested by the victim, a victim advocate, qualified agency staff member, or qualified community-based organization staff member is to accompany and support the victim through the forensic medical examination process and investigatory interviews and provide emotional support, crisis intervention, information, and referrals. At the time of the onsite audit, some interviews indicated a lack of awareness of protocols to be followed and a propensity for untrained staff to complete rogue investigative activities that might taint evidence or prejudice investigative interviews. Although these activities may be well intentioned because of desires to help and act quickly and decisively, they may inadvertently harm truth finding processes and disrupt the chain of evidence.
CAP: During the corrective action process the facility trained several investigators and provided verification of the training. These investigators also demonstrated their understanding during subsequent interviews. Other staff were also retrained and interviewed. They now indicate an adequate understanding of PREA protocols so it is clear they understand their role and will not contaminate evidence or sabotage investigative protocols if they are present when an incident is alleged or if they are first responders.

Standard 115.222 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

ATTC policy requires that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment

(including resident-on-resident sexual abuse and staff sexual misconduct). The agency has a policy that requires allegations of sexual abuse or sexual harassment be documented and referred for investigation. Agency policy regarding the referral of allegations of sexual abuse or sexual harassment was is in the process of being made publicly available. During the onsite audit, as well as in the PAQ, the CEO, Paul Walker, stated there have been no allegations. However, the audit team was provided with proof that an allegation had been made. Other interviews conducted, and information received, indicated there may have been other allegations, but documentation of any other allegations, if any, had not been provided to the audit team. This PREA standard was added to the compliance plan so that ATTC could verify they are following policy and making sure allegations get properly investigated.
CAP: To verify this standard, and to lower the risk of additional allegations being missed, the agency agreed to provide the audit team with all tickets, incident reports, allegations and grievances made during the corrective action period. This included all documentation, regardless of what form it was written on, or even if it was not on a form, regarding any suspicion of any inappropriate behavior or rule violations either by staff or residents. Two allegations were revealed and referred for investigation during the CAP. The audit team reviewed hundreds of pages of documentation that did not contain allegations of sexual abuse or harassment. Also, the agency provided verification of policy being publicly available as required in this standard.

Standard 115.231 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

ATTC intends to train all employees initially and annually, as verified by training logs and interviews, on the following matters: (1) The agency's zero-tolerance policy for sexual abuse and sexual harassment; (2) How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures; (3) The right of residents to be free from sexual abuse and sexual harassment; (4) The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment; (5) The dynamics of sexual abuse and sexual harassment in confinement; (6) The common reactions of sexual abuse and sexual harassment victims; (7) How to detect and respond to signs of threatened and actual sexual abuse; (8) How to avoid inappropriate relationships with residents; (9) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender-nonconforming residents; and (10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities. The facility has online training through Blue Basin. The audit team had been provided with verification that most staff had completed this training during the pre-audit work and the onsite audit, but some were pending.
CAP: Since there have been recent changes in PREA policy and since the Coordinated Response Plan was being updated, and since some staff did not understand PREA very well during the onsite audit, the facility agreed to train all staff on the facility's PREA policies and procedures and provide this verification during the corrective action timeframes. This was completed and the remaining Blue Basin training was completed as well. Also, interviews were conducted to verify a basic understanding of PREA as well as the agency PREA policies.

Standard 115.232 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

corrective actions taken by the facility.

All volunteers and contractors who have contact with ATTC residents have been trained on their responsibilities under the agency's policies and procedures regarding sexual abuse/harassment prevention, detection, and response. Training curriculum and documentation was provided to the auditor. The level and type of training provided to volunteers and contractors is based on the services they provide and level of contact they have with residents. All volunteers and contractors who have contact with residents have been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.

Standard 115.233 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

ATTC residents receive information at time of intake about the zero-tolerance policy, how to report incidents or suspicions of sexual abuse or harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents. Resident PREA education is available in formats accessible to all residents, including those who are: limited English proficient, deaf, visually impaired, otherwise disabled, and limited in their reading skills. The agency maintains documentation of resident participation in PREA education sessions. The agency ensures that key information about the agency's PREA policies is continuously and readily available or visible through posters, resident handbooks, or other written formats. During the onsite audit, the auditor observed the notices and posters, examined the training logs and materials, and interviewed randomly selected inmates. Residents did well answering questions that demonstrated their understanding of PREA.

Standard 115.234 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

ATTC and TDCJ policy requires that investigators are trained in conducting sexual abuse investigations in confinement settings. Specialized training should include techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral.
CAP: Investigators were trained and verification was provided to the audit team. Also, investigators were interviewed by the audit team.

Standard 115.235 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

ATTC PREA policy states on page 3, "The agency refers all medical and mental health care to outside resources." The PREA standard requires, if the care is provided inhouse, medical and mental health practitioners who may work with victims of sexual abuse are to be properly trained and the training must include: how to detect and assess signs of sexual abuse and sexual harassment; how to preserve physical evidence of sexual abuse; how to respond effectively and professionally to victims of sexual abuse and sexual harassment; and, how and to whom to report allegations or suspicions of sexual abuse and sexual harassment. The agency does not conduct forensic exams.

Standard 115.241 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

ATTC has a policy that requires screening for risk of sexual abuse victimization or sexual abusiveness toward other residents to be completed within 72 hours of arrival. Policy requires the facility reassess each resident's risk of victimization or abusiveness within a set time period, not to exceed 30 days after the resident's arrival at the facility, based upon any additional, relevant information received by the facility since the intake screening. The policy requires that a resident's risk level be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness. Policy prohibits disciplining residents for refusing to answer (or for not disclosing complete information related to) the questions regarding whether or not the resident has a mental, physical, or developmental disability; whether or not the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender non-conforming; whether or not the resident has previously experienced sexual victimization; and, the resident's own perception of vulnerability. The screening tool is required to consider, at a minimum, whether the resident has a mental, physical, or developmental disability; the age of the resident; the physical build of the resident; whether the resident has previously been incarcerated; whether the resident's criminal history is exclusively nonviolent; whether the resident has prior convictions for sex offenses against an adult or child; whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; whether the resident has previously experienced sexual victimization; and the resident's own perception of vulnerability. The screening form being used at the time of the onsite audit was incomplete. Apparently, it had been a multipage form, but only one page was being used. It does not appear that any residents had been screened as per a complete screening tool with minimum requirements. The residents also needed to be reassessed within 30 days. These compliance issues were addressed in the CAP.

CAP: The CAP required the following:

- Implement a screening tool that at least meets the minimum requirements of this standard. Implementation implies any necessary training, distribution, policy /procedure changes, and instructions for the screening to be properly conducted. Provide documentation of the screening tool, and the implementation process for the audit team to review.
- Provide screenings for the audit team to review for all residents at the facility.
- Provide reassessments for all residents at the facility who had been at the facility since April 1, 2017 or before.
- Provide auditor with examples of how risk factors have been considered while protecting sensitive information.
- Provide a log of any reassessments completed when additional information was received relating to risk of abusiveness or victimization.
- Everyone who completes screenings and reassessments will be interviewed by the audit team as per the PREA Resource Center interview guidelines.

The agency located the other pages of the screening tool and provided the complete tool for the audit team to review. It is a tool used by TDCJ for a number of years and has the minimum components required by PREA. ATTC started using the tool and provided the team with the screenings conducted, as well as with reassessments. Examples of risk factors being considered while protecting sensitive information, and of additional information pertinent to risk assessment being received after intake, had to be gleaned from interviews and other documentation since the agency did not log these items. Interviews conducted as part of the CAP indicated a basic understanding of the screening process and that it is in practice. The facility has always done screenings upon admission, and has been doing partial PREA screenings for more than a year, so these additional efforts bring them into compliance.

Standard 115.242 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Information from the risk screening required by § 115.241 is used to inform housing, bed, work, education, and program assignments with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive. Individualized determinations are to be made about how to ensure the safety of each resident. Housing and program assignments for transgender or intersex residents in the facility are to be made on a case-by-case basis. A transgender or intersex resident's own views with respect to his or her own safety is to be given serious consideration. Transgender and intersex residents are to be given the opportunity to shower separately from other residents. The agency shall not place lesbian, gay, bisexual, transgender, or intersex residents in dedicated units. Since the screening process had not been fully implemented at the time of the onsite audit, the auditor also needed to verify, during the compliance process, the way the information obtained during the screening is used.
CAP: All staff who have the authority to make housing, bed, work, education, and program assignments were identified and interviewed. They were asked whether they check the screening information themselves, or whether they check with someone familiar with the screening results, before assigning or reassigning a resident to a particular bed or program assignment. They were asked with whom they can share this information in order to verify compliance with 115.241 (i) about the confidentiality of sensitive information. Random staff were also selected and interviewed. They were asked whether they have the authority to change resident bed assignments without supervisory approval. Not only did the staff answer these questions appropriately to indicate an understanding of this standard, they gave examples of decisions that can be made dealing with unusual situations, during the night, or on weekends, that keep them in compliance with this standard. Also, interviews indicate TDCJ officials have been present in the facility a number of times recently, conducting a mock audit, investigating, mentoring/training, and otherwise assisting the facility to maintain practices compliant with PREA standards and other TDCJ policies. Interviews indicated that the staff at the facility now portray a culture inclusive of the spirit and letter of PREA, and that they also feel their leadership understands and supports PREA, and can provide helpful answers to their questions.

Standard 115.251 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency has established procedures allowing for multiple internal ways for residents to report privately to agency officials about sexual abuse or sexual harassment; retaliation by other residents or staff for reporting sexual abuse and sexual harassment; and staff neglect or violation of responsibilities that may have contributed to such incidents. The agency provides at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the agency. The agency has a policy mandating that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties. Staff are required to document verbal reports immediately or by the end of their shift. The agency has established procedures for staff to privately report sexual abuse and sexual harassment of residents verbally and in writing. Staff are informed of these procedures. All residents interviewed know they can report and all staff interviewed say they can take reports and know how to instruct and assist residents if they request to make a report.

Standard 115.252 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

ATTC has an administrative procedure for dealing with resident grievances regarding sexual abuse. Agency procedure allows a resident to submit a grievance regarding an allegation of sexual abuse at any time regardless of when the incident is alleged to have occurred. The policy does not require a resident to use an informal grievance process, or otherwise to attempt to resolve with staff, an alleged incident of sexual abuse. Agency policy and procedure requires that a resident grievance alleging sexual abuse not be referred to the staff member who is the subject of the complaint. A decision on the merits of any grievance or portion of a grievance alleging sexual abuse must be made within 90 days of the filing of the grievance. In the past 12 months, there have been no grievances filed that alleged sexual abuse. The agency always notifies the resident in writing when the agency files for an extension, including notice of the date by which a decision will be made. Third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, may assist residents in filing requests for administrative remedies relating to allegations of sexual abuse and to file such requests on behalf of residents. If the resident declines to have third-party assistance in filing a grievance alleging sexual abuse, the agency documents the resident's decision to decline. The agency also has established procedures for filing an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse. These require an initial response within 48 hours and a final agency decision within five days. ATTC PREA policy on page 5 states the response time is less than 24 hours. Policy limits the ability to discipline a resident for filing a grievance alleging sexual abuse to occasions where the agency demonstrates that the resident filed the grievance in bad faith. The following is quoted directly from the Agency Standards of Care: 448.702 Client Grievances Policy: Plainview Serenity Center, Inc. has a written client grievance procedure for the clients served which he/she is given a copy at time of orientation and within 24 hours of admission in which it is read and explained in language he/she can understand. This will be accomplished in clear and simple terms. The procedure will be explained within 24 hours after admission. The client grievance procedure is also posted at each facility site and/or extension sites.
The explanation of grievance procedure will include:

1. clients may file a grievance about any violation of client rights or commission rules or any complaint as he/she chooses
2. client will be explained on how to file and submit a grievance in writing on any violation of client rights or commission rules at time of orientation or as requested.
3. methods used to file a complaint
4. client may grieve directly to any staff member directly
5. client may have direct access to the program director and the governing body at some point in the grievance process
6. client may submit the complaint in writing and may have assistance with writing the complaint if they are unable to read or write
7. be provide pens, paper, envelopes, postage, and access to a telephone for the purpose of filing a complaint
8. file a complaint or grieve directly to the DSHS at any time or by phone or mail. 1-800-832-9623

HHSC-DSHS	DARS
1100 W. 49th Street	DAR Counselor
Austin, Texas 78753	504 S. Broadway, Plainview, TX
1-800-832-9623	(806)293-4636
Department of Investigations	1-800-628-5115

9. client may submit a complaint directly to Texas Department of State Health at any time or Texas Rehabilitation Commission if applicable.

Standard 115.253 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

ATTC provides 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) for local, state, or national victim advocacy or rape crisis organizations and enabling reasonable communication between residents and these organizations in as confidential a manner as possible. The facility informs residents, prior to giving them access to outside support services, of the extent to which such communications will be monitored and of mandatory reporting rules governing privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant federal, state, or local law. ATTC has posted contact information for Family Support Services at various locations around the facility. The auditor has contacted Family Support Services and verified they provide advocacy services for victims of sexual abuse.

Standard 115.254 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

ATTC provides a method to receive third-party reports of resident sexual abuse or sexual harassment. TDCJ also publicly distributes information on how to report resident sexual abuse or sexual harassment on behalf of residents. The auditor verified that staff and inmates are instructed about third party reporting, and the information is available publicly. Residents indicated they know about third party reporting and know how to do it.

Standard 115.261 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

ATTC requires all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency. It is also required that all staff report immediately any retaliation against residents or staff who reported such an incident. All staff are to report immediately and according to agency policy any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Apart from reporting to designated supervisors or officials and designated state or local services agencies, agency policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions. Policy also requires all allegations be reported to designated investigators. During the onsite audit, the audit team was informed about an allegation that had not been properly assigned for investigation.
CAP: The CAP agreement required all other allegations that came in during the past 12 months, and during the CAP timeframe, be appropriately reported and assigned for investigation, and also reported to the audit team. Two other allegations/suspicions of violations of the agency's abuse/harassment and related policies were identified and investigated appropriately, in addition to the one discovered during the audit, according to the information provided to the audit team.

Standard 115.262 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

When ATTC learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident (i.e., it takes some action to assess and implement appropriate protective measures without unreasonable delay). In the past 12 months, there have been no times the agency determined that a resident was subject to substantial risk of imminent sexual abuse. This information was verified by a reading of policy and interviews with residents and staff.

Standard 115.263 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The auditor confirmed that the agency has a policy requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility must notify the head of the facility or appropriate office of the agency or facility where sexual abuse is alleged to have occurred. During the past 12 months, the facility has not received any allegations that a resident was abused

while confined at another facility. Agency policy requires the facility head to provide such notification as soon as possible, but no later than 72 hours after receiving the allegation. ATTC PREA Policy on page 6 promises this notification will be made within 24 hours. The facility documents that it has provided such notification within 72 hours of receiving the allegation. Facility policy requires that allegations received from other facilities and agencies are investigated in accordance with the PREA standards. Information received during the audit indicates that in the past 12 months, there have been no allegations of sexual abuse the facility received from other facilities. CEO Paul Walker indicates an understanding of this standard and policy.

Standard 115.264 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

ATTC has a first responder policy for allegations of sexual abuse. This policy requires that, upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report shall be required to separate the alleged victim and abuser and to preserve and protect any crime scene until appropriate steps can be taken to collect any evidence. If the abuse occurred within a time period that still allows for the collection of physical evidence, the first responder is 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, staff is 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. During the onsite audit, some first responder staff did not seem to know their first responder duties, and did not know where to look to find out. Since the onsite audit, but before the Interim Report was completed, Mr. Walker designed First Responder cards and distributed them to staff.
CAP: Random staff were selected and interviewed by the audit team, by phone, and they indicated an understanding of their duties.

Standard 115.265 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

At the time of the onsite audit, ATTC was developing an updated written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership in the event of an incident of sexual abuse.
CAP: The Coordinated Response Plan was provided to the audit team as part of the corrective action plan.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency has not entered into or renewed any collective bargaining agreement or other agreement since August 20, 2012. They retain the ability to protect residents from abuse.

Standard 115.267 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

ATTC has 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. Policy indicates ATTC will monitor the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff. ATTC is required to monitor conduct and treatment for 90 days, or longer if indicated, and to act promptly to remedy any retaliation. No incidents of retaliation in the past 12 months are known. ATTC is required to use 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. ATTC is also required to monitor resident disciplinary reports, housing, and program changes, as well as negative performance reviews and reassignments of staff. Monitoring includes periodic status checks. Since ATTC PREA leadership has experienced interruption and/or change, and since this standard depends on the investigative process being properly completed, verification of compliance with this standard could not be completed until other items were completed in the CAP.
CAP: ATTC policy had already been reviewed during the pre and onsite audit process. Investigations were completed during the CAP process, and provided to the audit team. In addition to reviewing documentation provided, the audit team interviewed administrators with retaliation monitoring duties in order to verify compliance with this standard.

Standard 115.271 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

corrective actions taken by the facility.

ATTC has written policy related to criminal and administrative agency investigations. Substantiated allegations of conduct that appear to be criminal are required to be referred for prosecution. Policy requires the agency to retain all written reports pertaining to the administrative or criminal investigation of alleged sexual abuse or sexual harassment for as long as the alleged abuser is incarcerated or employed by the agency, plus five years. Investigations are to be done promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports. Investigators who have received special training in sexual abuse investigations must be used. Investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; they shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator. When the quality of evidence appears to support criminal prosecution, the agency shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution. The credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person's status as resident or staff. A polygraph examination is not to be required. Administrative investigations shall include an effort to determine whether staff actions or failures to act contributed to the abuse; and shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. Criminal investigations shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible. The departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation.
CAP: Documentation of all investigations conducted by the facility, and other pertinent documentation, was reviewed during the corrective action period to determine compliance with this standard. In addition, investigators were retrained and interviewed.

Standard 115.272 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

ATTC policy states that the agency will impose a standard of a preponderance of the evidence, or a lower standard of proof, when determining whether allegations of sexual abuse or sexual harassment are substantiated in administrative investigations. Interviews conducted, and documentation provided at the time of the Interim Report, did not verify an understanding of this standard, or compliance with related policy.
CAP: During the CAP, the facility provided verification that administrators and investigators were retrained. They also showed compliance and understanding through investigations completed and through telephonic interviews conducted by the audit team.

Standard 115.273 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility has a policy requiring that any resident who makes an allegation that he or she suffered sexual abuse in ATTC is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation. If an outside entity conducts such investigations, the facility is required to request the relevant information from the investigative entity in order to inform the resident of the outcome of the investigation. Also, following a resident's allegation that a staff member has committed sexual abuse against the resident, the agency/facility is required to subsequently inform the resident (unless the agency has determined that the allegation is unfounded) whenever the staff member is no longer posted within the residence, the staff member is no longer employed at the facility, the agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility, or, the agency/facility learns that the staff member has been convicted on a charge related to sexual abuse within the facility. Following a resident's allegation that he or she has been sexually abused by another resident, the agency is required to subsequently inform the alleged victim whenever the agency/facility learns that the alleged abuser 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. By policy, and contractual agreement with TDCJ, all notifications to residents described under this standard are to be documented.
CAP: There was a pending investigation at the facility which was completed during the CAP. Interviews, and a review of documents, verified the facility administrators and investigators understand and practice the notification/reporting requirements.

Standard 115.276 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy requires ATTC staff to be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. In the past 12 months leading up to the audit, and the months evaluated for the CAP, there were at least 2 staff from the facility who allegedly violated agency sexual abuse or sexual harassment policies.
CAP: ATTC provided verification of compliance with this standard during the corrective action period. The disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) were 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. 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, are to be reported to law enforcement agencies (unless the activity was clearly not criminal) and to any relevant licensing bodies. The staff member who resigned while under investigation, and the staff member who is no longer assigned to work with residents at ATTC, were determined to have not engaged in any criminal activity.

Standard 115.277 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies (unless the activity was clearly not criminal) and to relevant licensing bodies. Agency policy requires that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents. In the past 12 months, there have been no contractors or volunteers alleged to have engaged in sexual abuse or harassment of residents, so none have been reported to law enforcement agencies and relevant licensing bodies. The facility takes appropriate remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer. Compliance with this standard was established through a review of HR files, review of policy, and interviews. It does not appear that any contractors or volunteers engaged in sexual abuse of residents in the 12 months reviewed for the audit or in the months evaluated for the CAP.

Standard 115.278 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

ATTC residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding, or a criminal finding of guilt, that a resident engaged in resident-on-resident sexual abuse. Sanctions are commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories. The disciplinary process considers 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. Residents are referred off site for any therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse. The facility considers whether to require the offending resident to participate in such interventions as a condition of access to programming or other benefits. The agency disciplines residents for sexual conduct with staff only upon finding that the staff member did not consent to such contact. The agency prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation. Having said all that, it is very unlikely any abusive resident would remain at the facility. He or she would probably be transferred out or jailed. The agency prohibits all sexual activity between residents but deems such activity to constitute sexual abuse only if it determines that the activity is coerced. Compliance with this standard was established by a review of policy, a review of documentation provided, and interviews conducted with administrators and specialized staff. It does not appear there were any substantiated findings of resident on resident sexual abuse, or associated sanctions, during the 12 months evaluated for the onsite audit or for the period of time that passed during the CAP.

Standard 115.282 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

ATTC resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services.

The nature and scope of such services are determined by medical and mental health practitioners according to their professional judgment. Medical and mental health staff maintain secondary materials documenting the timeliness of emergency medical treatment and crisis intervention services that were provided and the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported, and the provision of appropriate and timely information and services concerning contraception and sexually transmitted infection prophylaxis. Resident victims of sexual abuse while incarcerated are offered timely information about and timely access to sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. Treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Verification of this standard was established through review of policy, the coordinated response plan, and interviews. The auditor interviewed Becky O'Neal, the SANE Supervisor at Northwest Hospital and she verifies these services are available to ATTC residents. Also she verifies that she works regularly with Family Support Services, the agency identified by ATTC to provide advocacy and aftercare.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

ATTC offers medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility. Services that cannot be provided inhouse are referred out. Female victims of sexually abusive vaginal penetration while incarcerated are offered pregnancy tests. If pregnancy results from sexual abuse while incarcerated, victims receive timely and comprehensive information about, and timely access to, all lawful pregnancy-related medical services. Resident victims of sexual abuse while incarcerated are 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 offers treatment when deemed appropriate by mental health practitioners. Treatment services are 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. Compliance was verified through a review of policy and interviews conducted at the facility with administrators who indicate an understanding of this policy. The audit team also verified the availability of off site services to residents at ATTC.

Standard 115.286 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility conducts a sexual abuse incident review at the conclusion of every criminal or administrative sexual abuse investigation, unless the allegation has been determined to be unfounded. The facility ordinarily conducts a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation. The sexual abuse incident review team includes upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners who report their

findings and any recommendations for improvement to the facility head. The facility implements the recommendations for improvement or documents its reasons for not doing so. The team considers whether policies or practices need to be changed; whether the incident or allegation was motivated by race, ethnicity, LGBTI status or perceived status, or gang affiliation or other group dynamics at the facility; whether physical barriers in the area where the abuse allegedly occurred might enable abuse; and whether monitoring technology should be augmented or changed. Compliance with this standard was based on a review of policies, investigative documentation and interviews.

Standard 115.287 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

ATTC and TDCJ collect accurate, uniform data for every allegation of sexual abuse using a standardized instrument and set of definitions. The standardized instrument includes, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence (SSV) conducted by the Department of Justice. They aggregate the incident-based sexual abuse data at least annually and maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. The PAQ and interviews indicate compliance with this standard.

Standard 115.288 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

ATTC reviews data collected and aggregated pursuant to §115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, response policies, and training, including: identifying problem areas; taking corrective action on an ongoing basis; and preparing an annual report of its findings from its data review and any corrective actions for each facility, as well as the agency as a whole. **CAP:** ATTC's annual report had not yet been released at the time of the onsite audit. It was released during the CAP and included a comparison of the current year's data and corrective actions with those from prior years. The annual report provided an assessment of the agency's progress in addressing sexual abuse. It made its annual report readily available to the public, once approved by the agency head.

Standard 115.289 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

ATTC securely retains incident-based and aggregate data. Policy requires that aggregated sexual abuse data is made readily available to the public at least annually. Before making aggregated sexual abuse data publicly available, the agency is required to remove all personal identifiers. The agency is required to maintain sexual abuse data collected pursuant to §115.287 for at least 10 years after the date of initial collection, unless federal, state, or local law requires otherwise.
CAP: At the time of the onsite audit, ATTC had not yet compiled or published their annual report. During the CAP, they compiled their report and posted public notices that the report is available to the public. They also provided their report to TDCJ.

AUDITOR CERTIFICATION

I certify that:

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

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

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

D. Will Weir _ 07-14-2017

Auditor Signature Date