

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

Interim Final

Date of Report 10-23-2019

Auditor Information

Name: David "Will" Weir Email: will@preaamerica.com

Company Name: PREA America, LLC

Mailing Address: P. O. Box 1473 City, State, Zip: Raton, NM 87740

Telephone: 405-945-1951 Date of Facility Visit: 09-16-2019

Agency Information

Name of Agency: Clover House, Inc. Governing Authority or Parent Agency (If Applicable):

Physical Address: 3603 Andrews Highway City, State, Zip: Odessa, TX 79762

Mailing Address: Click or tap here to enter text. City, State, Zip: Click or tap here to enter text.

The Agency Is: Military Private for Profit Private not for Profit

Municipal County State Federal

Agency Website with PREA Information: <http://www.cloverhouseinc.com/>

Agency Chief Executive Officer

Name: Rally Q. Flores

Email: clovered@cableone.net Telephone: 432-580-0321

Agency-Wide PREA Coordinator

Name: Rally Q. Flores

Email: clovered@cableone.net Telephone: 432-580-0321

PREA Coordinator Reports to: Board of Directors Number of Compliance Managers who report to the PREA Coordinator: 1

Facility Information

Name of Facility: Clover House, Inc.

Physical Address: 300 N. Jackson

City, State, Zip: Odessa, TX 79761

Mailing Address (if different from above):
3603 Andrews Highway

City, State, Zip: Odessa, TX 79762

The Facility Is:

Military

Private for Profit

Private not for Profit

Municipal

County

State

Federal

Facility Website with PREA Information: <http://www.cloverhouseinc.com/>

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

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

ACA

NCCHC

CALEA

Other (please name or describe: [Click or tap here to enter text.](#))

N/A

If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe:
N/A

Facility Director

Name: Rally Q Flores

Email: clovered@cableone.net

Telephone: 432-580-0321

Facility PREA Compliance Manager

Name: Larrinda Williams

Email: chtrainer@cableone.net

Telephone: 432-580-0321

Facility Health Service Administrator N/A

Name: [Click or tap here to enter text.](#)

Email: [Click or tap here to enter text.](#)

Telephone: [Click or tap here to enter text.](#)

Facility Characteristics

Designated Facility Capacity:	125	
Current Population of Facility:	91	
Average daily population for the past 12 months:	103	
Has the facility been over capacity at any point in the past 12 months?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Which population(s) does the facility hold?	<input type="checkbox"/> Females <input type="checkbox"/> Males <input checked="" type="checkbox"/> Both Females and Males	
Age range of population:	Adults 18+	
Average length of stay or time under supervision	60 Days	
Facility security levels/resident custody levels	Non-secure	
Number of residents admitted to facility during the past 12 months	760	
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:	749	
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 30 days or more:	651	
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
<p>Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):</p>	<input type="checkbox"/> Federal Bureau of Prisons <input type="checkbox"/> U.S. Marshals Service <input type="checkbox"/> U.S. Immigration and Customs Enforcement <input type="checkbox"/> Bureau of Indian Affairs <input type="checkbox"/> U.S. Military branch <input checked="" type="checkbox"/> State or Territorial correctional agency <input type="checkbox"/> County correctional or detention agency <input type="checkbox"/> Judicial district correctional or detention facility <input type="checkbox"/> City or municipal correctional or detention facility (e.g. police lockup or city jail) <input type="checkbox"/> Private corrections or detention provider <input type="checkbox"/> Other - please name or describe: Click or tap here to enter text. <input type="checkbox"/> N/A	
Number of staff currently employed by the facility who may have contact with residents:	62	
Number of staff hired by the facility during the past 12 months who may have contact with residents:	24	

Number of contracts in the past 12 months for services with contractors who may have contact with residents:	0
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	4 nurses
Number of volunteers who have contact with residents, currently authorized to enter the facility:	3
Physical Plant	
<p>Number of buildings:</p> <p>Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.</p>	3
<p>Number of resident housing units:</p> <p>Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.</p>	4
Number of single resident cells, rooms, or other enclosures:	0
Number of multiple occupancy cells, rooms, or other enclosures:	34
Number of open bay/dorm housing units:	1
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Medical and Mental Health Services and Forensic Medical Exams

Are medical services provided on-site?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Are mental health services provided on-site?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Where are sexual assault forensic medical exams provided? Select all that apply.	<input type="checkbox"/> On-site <input checked="" type="checkbox"/> Local hospital/clinic <input type="checkbox"/> Rape Crisis Center <input type="checkbox"/> Other (please name or describe: Click or tap here to enter text.)

Investigations

Criminal Investigations

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

Administrative Investigations

Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?	4
When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: Select all that apply	<input checked="" type="checkbox"/> Facility investigators <input checked="" type="checkbox"/> Agency investigators <input checked="" type="checkbox"/> An external investigative entity
Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)	<input checked="" type="checkbox"/> Local police department <input checked="" type="checkbox"/> Local sheriff's department <input checked="" type="checkbox"/> State police <input type="checkbox"/> A U.S. Department of Justice component <input type="checkbox"/> Other (please name or describe: Click or tap here to enter text.) <input type="checkbox"/> N/A

Audit Findings

Audit Narrative

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

Early in 2019, Clover House, Inc., started inquiries regarding the need for their next PREA Audit. On July 12, PREA America was retained to complete the audit. The on-site audit date of September 16, 2019 was selected. The PREA America audit team consisted of Project Manager Tom Kovach and DOJ Certified PREA Auditor Will Weir. Introductory communication with the PREA Coordinator to discuss the audit process, audit preparation the Pre- Audit Questionnaire (PAQ) and supporting documents and elements of the on-site visit, took place shortly after scheduling the on-site audit date. The Audit Notice Posting was sent, with instructions to print on color paper, and about proper distribution of the posting. Alternative language posting was also made available. Proof of posting was verified by photos emailed on July 18th, of the various locations in the facility where the postings were placed. The date of the email was used to verify the minimum posting requirements of six weeks, along with observations of the postings during the physical plant tour.

During the Pre-Audit Phase, the audit team engaged an extensive desk audit of the facility/agency, including reviews of the PAQ, policies, procedures, and supporting documentation. Several emails were exchanged to clarify issues. This phase of the audit was used to collaborate with the facility staff, regarding questions and concerns about documenting compliance. The communication with the facility staff was used not only to understand the policies and procedures unique to the facility, but also to understand how PREA was put into practice. Internet research was done on the facility.

All received documents were reviewed, including logs, training files, and curriculum. In order to verify compliance both with the 5-year-recheck requirement and with the initial background check, files were randomly selected of staff. Residents were randomly selected to verify PREA education and PREA Screenings. Phone calls were made to listed advocates, to verify the advocacy required by the Standards. Also reviewed was the Agency Mission, report of external audit, population reports, staff lists & schedules, and the facility schematics.

The on-site audit was held September 16, as scheduled, and started with a briefing which included confirmation of current population (91 residents), review of agenda and logistics, discussion of mandatory reporting, and clarification of the need to allow any staff or resident who requests an interview to get one. The audit team checked to see if there were questions or concerns.

The Site Review included obtaining and studying the facility diagrams of the physical plants. The supervision and movement of staff and residents were observed. Casual conversations were held to ascertain whether observations made were of "normal" supervision and movement. Random checks

were made to assure doors intended to be secured were locked. Random checks were engaged of PREA Hotline phones to ensure that they were functioning. All housing units and bathroom facilities were inspected for compliance for cross-gender supervision. This included a camera review for those areas with cameras. All areas of the physical plants were observed, with attention to those areas which statistically are high-risk for sexual abuse. PREA Postings, including third-party reporting postings in the visitation areas, were checked. Confirmation of the availability to staff of hard copies of First Responder Duties was also a part of the tour. Blind spots were identified, and procedures for checking them were verified.

Interviews were selected in accordance with the guidance of the PREA Auditor Handbook, with random selections of residents to ensure diversity of geographic location (from each housing unit), race, and those with risk factors. Random Staff interviews were made to include gender, shift, and posting diversity. Interviews were in a conversational manner, to gain the confidence of those interviewed and to put them at ease, so that the audit team could better understand their comprehension of PREA and the practice in the facility.

22 of the 91 residents were interviewed. Administrators had initially been unable to produce a complete list for targeted interviews as required by the PREA Auditor Handbook. More information regarding this problem is provided in the narrative of this report regarding Standard 115.242. Only 7 of the interviews conducted were “targeted” interviews as per the guidelines of the Handbook. However, some of these residents represented numerous areas considered to contribute to risk for sexual abuse, and they were interviewed accordingly. The audit team was able to interview residents with multiple medical needs or disabilities, special needs, LGBTI perceived or actual status, and with prior offenses (considered to increase risk in correctional settings). 11 of the interviews conducted were with female residents.

The following interviews of staff were conducted: PREA Coordinator, Executive Director, Human Resources, Investigators, PREA Compliance Manager, First Responders, Supervisors, Clinical Staff, Staff who perform Screening and Intake, Staff who monitor for Retaliation, Incident Review Team, and Staff who provide Transportation and Referrals. Due to these specialized staff performing multiple duties, 4 staff were questioned related to these duties. An additional twelve staff were selected randomly representing various, stations, housing units, shifts and genders. As with specialized staff, the randomly selected staff also perform multiple duties and also assist specialized staff, so these staff were also questioned regarding multiple aspects of their work. A total of 16 unique interviews were conducted.

The exit briefing was conducted at the end of the day, addressing all aspects of the audit to date. No determination of compliance was given. The recap of the aggregated information obtained and observed was summarized. At the request of the facility staff, this summary included a SWOT briefing (describing the facility’s Strengths, Weaknesses, Opportunities, and Threats), in order to assist in furthering the efforts of the facility to prevent and detect sexual abuse and harassment. Two issues were discussed in the exit briefing and resolved in the 30 days after the on-site audit.

The first issue involved the difficulty encountered in identifying residents by the way they answered questions in their confidential screenings for risk of victimization or abusiveness. Agencies must be able to use information from the risk screenings to inform housing, bed, work, education, program assignments. In practice, some of the information obtained in screenings was not available to the Clover House administrators who were making these housing, bed, work, education, program assignments. The agency had been utilizing information regarding high risk determinations, but not about single and/or subtle risk factors, such as history of sexual victimization. The “Client Potential Risk Factor Review” was developed and implemented by the Clinical Director within one week after the on-

site audit. Examples of the use of this new tool were provided to the audit team to verify practice. The system is designed to provide the maximum protections to residents while using the least amount of specific sensitive information in the process and continuing to restrict information sharing only to administrators who need to know the information.

The second issue involved the agency website. Historically, Clover House has posted notices in visitation areas to inform the public that PREA policies and annual reports are available upon request. Although these notices are still up, the agency has recently created a website as an improved method to provide information to the public as required in Standards 115.288 and 115.289.

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.

Although Clover House, Inc., operates just one correctional facility, the facility has three programs, each of which have with one housing unit. Although the programs are geographically close, each has a different address. The three programs are (1) Dixie Women's Residential; (2) Jackson Men's Residential; and (3) Idlewood Men's Intensive. There is a single responsible agency, and there is a single Administrator for all the programs who answers directly to the Board. There is one set of policies and procedures. The resident populations are similar. There is some resident mingling, although this is more limited between men and women residents, and many staff are interchangeable, meaning that they are trained to work at and can be assigned shifts at more than one of the three programs. The three share a unified mission and identical reporting mechanisms. These are the factors the Department of Justice offers for guidance in determining whether it is one or several distinct facilities for the purposes of the audit. Programming includes substance abuse treatment, which is also a consideration in staffing assignments.

The housing units are named for the street on which they are located. Jackson is the largest, with two levels. It houses adult male clients. It has an extensive camera system, but it does not view areas where residents toilet or shower. The rectangular-shaped building has its main entrance in the middle, and it has exits on both sides. The front office is to the right, and the stairs to the second level are on the left. There is a long hall connecting the various 5 rooms with the 5 offices, kitchen, dining room, and group room. There is also a freezer room across from the kitchen. The dining area and kitchen are in the middle, with a kitchen office for the kitchen manager and large pantry. There are stairs on the right end of the building, sandwiched between the kitchen and two offices on the end. Across the hall are two bedrooms. The left end of the building has three offices in a row, by the stairs; then a bedroom with multiple beds. This is across from the men's and women's bathrooms, next to which are three rooms which you must go through to get to the next. Jackson had 428 admissions in the past 12 months, 423 stayed for more than 72 hours, and 364 admitted residents stayed longer than 30 days.

Dixie Women's Residential is a single building, designed for 30 residents in 10 multi-occupancy rooms, with an average daily population of 28 adult females. In the past 12 months, there were 190 residents admitted, 187 for more than 72 hours, 167 for more than 30 days. 19 staff have contact with the residents, of whom 7 were hired in the past year. There are two contract nurses. The laundry and dining areas are next to 6 of the rooms, with an office and a reception separating them from 3 more rooms and the North Bathroom. Adjacent to these are a dorm with a separate bathroom. 8 video cameras cover non-sleeping areas.

Idlewood Men's Intensive Residential has a single building with 5 multi-occupancy rooms. It is designed for 15 residents, and it has had an average daily population of 11 adult males. The average stay is 30 days. In the last year, there have been 142 admissions, of which 139 were there over 72 hours and 120 for 30 days. There are 13 staff who have contact with the residents, 5 of whom were hired in the last year. They share two contract nurses. The building has 6 cameras, which cover all common areas, excluding sleeping areas and bathrooms. One side of the building has the 5 resident rooms, with a closet and bathroom. They are next to a day room and kitchen, which is flanked by the three offices and reception.

Summary of Audit Findings

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

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

Standards Exceeded

Number of Standards Exceeded: 0

List of Standards Exceeded: Click or tap here to enter text.

Standards Met

Number of Standards Met: 41

Standards Not Met

Number of Standards Not Met: 0

List of Standards Not Met: Click or tap here to enter text.

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.

Clover House, Inc., has a written policy mandating zero tolerance. The policy outlines how Clover House prevents, detects, and responds to sexual abuse and sexual harassment, and includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment and sanctions for those found to have participated in prohibited behaviors. The Clover House Executive Director is also the PREA Coordinator. She answers directly to the Board of Directors. She has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA Standards. She demonstrates an understanding of PREA, and she has extensive experience working in these current positions, and also with (and for) the Texas Department of Criminal Justice (TDCJ). In addition, the facility has a PREA Compliance Manager that answers directly to the Director/PREA Coordinator.

Analysis: During the onsite audit, the auditor verified the PREA policies to be in place and available to staff and residents. Signs regarding zero-tolerance, how to report, and how to receive services regarding sexual abuse, are prominently posted around the buildings that contain housing units and visitation areas. Staff, including administrators, and residents interviewed, indicated an understanding of the zero-tolerance policy, how to report, and how to receive advocacy and other services. The agency policy mandating zero tolerance of all forms of sexual abuse and sexual harassment is found in Policy Manual (PM) 14.4 and Administrative Policy (AM) 4. The agency organizational chart is consistent with policies reviewed, and interviews conducted, regarding PREA coordination at Clover House.

Finding: The agency has shown compliance with 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.) 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.

The agency accepts residents contractually from the Texas Department of Criminal Justice (TDCJ), but it does not contract out for the confinement of residents.

Analysis: Evidence, including documentation submitted and considered for compliance with this Standard, includes the Pre-Audit Questionnaire, interviews, and emails exchanged with the agency contract administrator and PREA Coordinator, Clover House policies, organizational chart, and contract with TDCJ. No conflicting information regarding the applicability or compliance with this Standard was noted.

Finding: The agency has shown compliance with this Standard.

Standard 115.213: Supervision and monitoring

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

115.213 (a)

- Does the facility have a documented staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?
 Yes No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The physical layout of each facility? Yes No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The composition of the resident population? Yes No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The prevalence of substantiated and unsubstantiated incidents of sexual abuse? Yes No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors? Yes No

115.213 (b)

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

115.213 (c)

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

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Clover House, Inc., has a documented 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. The staffing plan is reviewed annually for necessary adjustments in staffing patterns, the deployment of video monitoring systems and other monitoring technologies, and the allocation of facility/agency resources to commit to the staffing plan to ensure compliance with the staffing plan.

Analysis: Documentation submitted and considered for compliance with this Standard includes the Staffing Plan and Staffing Plan Review. Documentation of deviations from the Staffing Plan and written justifications for all such deviations was provided in the form of policy only, since there have been no deviations from the plan, as indicated in interviews and in the PAQ. Interviews with the Director of Human Resources and the PREA Coordinator also indicated compliance. The Staffing Plan development process was based on Chapter 448: Standard of Care. No staff or resident interviews indicated any incidents of staffing plan deviations, nor times when the facility was not adequately staffed.

Finding: The agency has shown compliance with this Standard.

Standard 115.215: Limits to cross-gender viewing and searches

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

115.215 (a)

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

115.215 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches of female residents, except in exigent circumstances? (N/A if the facility does not have female residents.)
 Yes No NA
- Does the facility always refrain from restricting female residents' access to regularly available programming or other outside opportunities in order to comply with this provision? (N/A if the facility does not have female residents.) Yes No NA

115.215 (c)

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

115.215 (d)

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

115.215 (e)

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

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

115.215 (f)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

The facility does not conduct strip or visual body cavity searches. If an emergency indicated these kinds of searches were required, the police would be called. The facility also forbids cross-gender pat-downs of residents. Pat searches of residents are witnessed and documented. 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. Policy prohibits staff from searching or physically examining a transgender or inter-sex resident for the sole purpose of determining the resident's genital status.

Analysis: Evidence, including documentation submitted and considered for compliance with this Standard, includes training curricula, Policy A.M. 413 (b and c), interviews with randomly selected staff and residents, staff training logs, and search logs. Interviews indicate that no cross-gender searches have occurred in the past 12 months, and the facility does not restrict residents' access to regularly

available programming or other outside opportunities in order to comply with this provision. Adequate male and female staff are scheduled at all times. Staff have received training on conducting searches of transgender and inter-sex residents in a professional and respectful manner, consistent with security needs. Clover House, Inc., does not accept any residents under the age of 18, so parts of Standards regarding youthful residents do not apply.

Finding: The agency has shown compliance with 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.

The facility 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.

Analysis: Evidence, including documentation submitted and considered for compliance with this Standard, includes: Policy AM 4.3; written materials used for effective communication about PREA with residents with disabilities or limited reading skills; documentation of staff training on PREA compliant practices for residents with disabilities; and interviews with the agency director, staff, and residents. The 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.

Finding: The agency has shown compliance with this Standard.

Standard 115.217: Hiring and promotion decisions

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

115.217 (a)

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

the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? Yes No

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

115.217 (b)

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

115.217 (c)

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

115.217 (d)

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

115.217 (e)

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

115.217 (f)

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

115.217 (g)

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

115.217 (h)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Clover House, Inc., 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; 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 that any incidents of sexual harassment be considered in determining whether to hire or promote anyone, or whether 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, the agency conducts criminal background record checks; and, consistent with federal, state, and local law, that the agency 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. Clover House, Inc., requires potential employees to sign a release of information to enable full cooperation by former employers. 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, but TDCJ also provides background checks and has a system in place that monitors data bases to detect any arrests.

Policy clearly states that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination. Policy also states that all applicants and employees who may have contact with residents will be asked about previous misconduct 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 also imposes upon employees a continuing affirmative duty to disclose misconduct. Policy also clearly states that, unless prohibited by law, the agency will 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 an employee has applied to work.

Analysis: Evidence reviewed includes policy AM 4.3 4.10, and PM 14.1; employment application forms; and files of 7 randomly selected staff. All interviews with administrators involved in hiring confirm these policies are being followed. Several personnel files were randomly pulled, verifying that current background checks have been performed. Documentation reviewed, and interviews conducted, indicate that these policies and practices have been in place for a number of years.

Finding: The agency has shown compliance with this Standard.

Standard 115.218: Upgrades to facilities and technologies

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

115.218 (a)

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

115.218 (b)

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

Auditor Overall Compliance Determination

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

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

Instructions for Overall Compliance Determination Narrative

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Clover House, Inc., has not acquired a new facility, nor made a substantial expansion or modification to existing facilities, since the last audit. Only minor updates to their video surveillance systems have been made.

Analysis: Evidence, including documentation submitted and considered for compliance with this Standard, includes: Interviews with the Director, facility schematics, site review, and demonstration of monitoring technology. Interviews indicate that sexual safety is one of the top considerations when updates are planned and implemented.

Finding: The agency has shown compliance with this Standard.

RESPONSIVE PLANNING

Standard 115.221: Evidence protocol and forensic medical examinations

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

115.221 (a)

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

115.221 (b)

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) Yes No NA
- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice’s Office on Violence Against Women publication, “A National

Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents,” or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) Yes No NA

115.221 (c)

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

115.221 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? Yes No
- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? (N/A if agency *a/ways* makes a victim advocate from a rape crisis center available to victims.) Yes No NA
- Has the agency documented its efforts to secure services from rape crisis centers? Yes No

115.221 (e)

- As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews? Yes No
- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? Yes No

115.221 (f)

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

115.221 (g)

- Auditor is not required to audit this provision.

115.221 (h)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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Clover House, Inc., is responsible for conducting administrative sexual abuse investigations. TDCJ and local law enforcement have responsibility for conducting administrative and criminal investigations. All residents who experience sexual abuse 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 the Emergency Room and the Crisis Center, but when SANEs or SAFEs are not available, a qualified medical practitioner performs forensic medical examinations. The facility documents efforts to provide SANEs or SAFEs.

In the past 12 months, there have been no forensic medical exams conducted, because there were no allegations. The facility attempts 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 documented. When a rape crisis center is not available to provide victim advocate services, the facility provides 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 accompanies and supports the victim through the forensic medical examination process and investigatory interviews and provides emotional support, crisis intervention, information, and referrals.

Analysis: Evidence, including documentation submitted and considered for compliance with this Standard, includes: Policies AM 4.4, 4.9, 4.18, 4.11 and 4.12; MOUs; contracts; National Institutes of Corrections Certificates of Training for 4 investigators; and PREA training for staff. Although it is unlikely that Clover House staff will have to serve as advocates during exams, a number of experienced and trained staff have been screened to perform these duties if needed.

Finding: The agency has shown compliance with this Standard.

Standard 115.222: Policies to ensure referrals of allegations for investigations

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

115.222 (a)

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

115.222 (b)

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

115.222 (c)

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

115.222 (d)

- Auditor is not required to audit this provision.

115.222 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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Clover House, Inc., ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment (including resident-on-resident sexual abuse or staff sexual misconduct). During the past 12 months, there have been no allegations of sexual abuse and sexual harassment that were received, and no investigations performed. The agency has a policy that requires that allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. The agency’s policy regarding the referral of allegations of sexual abuse or sexual harassment for criminal investigation is made publicly available. If there ever are any referrals or allegations of sexual abuse or sexual harassment for criminal investigation, the agency documents all such referrals.

Analysis: Evidence, including documentation submitted and considered for compliance with this Standard, includes policy AM 4; training curriculum; and interviews with SANE provider, investigative staff, and PREA Coordinator.

Finding: The agency has shown compliance with this Standard.

TRAINING AND EDUCATION

Standard 115.231: Employee training

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

115.231 (a)

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

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

115.231 (b)

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

115.231 (c)

- Have all current employees who may have contact with residents received such training? Yes No
- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? Yes No

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

115.231 (d)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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Clover House, Inc., trains 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.

Analysis: Evidence, including documentation submitted and considered for compliance with this Standard, includes the training policy and procedures (policy AM 4.5); interviews with randomly selected staff; and the training curriculum. 7 randomly selected employee files were pulled to verify training, and training logs for all staff were reviewed, as well. Some interviews with residents indicated that the staff maintain professionalism and employ excellent communication skills, allowing the residents to feel safe and to live in an atmosphere of trust and mutual respect superior to what they experienced in previous facilities.

Finding: The agency has shown compliance with this Standard.

Standard 115.232: Volunteer and contractor training

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

115.232 (a)

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

115.232 (b)

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

115.232 (c)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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Currently, Clover House, Inc., utilizes very few volunteers or contractors, and these are mainly off-site. All volunteers and contractors who have contact with residents are notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment, and they are informed how to report such incidents. The agency maintains documentation confirming that volunteers and contractors who have contact with residents understand the training they have received.

Analysis: Evidence, including documentation submitted and considered for compliance with this Standard, includes training curricula and policies regarding volunteers and contractors. The training

curriculum for volunteers and contractors is the same as that of employees. Compliance with this Standard was also verified in interviews with administrators who work with contractors.

Finding: The agency has shown compliance with 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.

Clover House, Inc., 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.

Analysis: Interviews with intake staff and randomly selected residents clearly indicate consistent application of this Standard. As indicated in the site review and in documentation reviewed, 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. Evidence reviewed includes policy AM 4.3 and 4.5. Intake records were reviewed of 10 randomly selected residents. Intake staff indicate they can make education materials available in formats accessible to residents who have limited English proficiency, deafness, visually impairment, or other disabilities, as well as to residents who have limited reading skills. Although no residents were identified who were deaf, other residents with various diagnoses were interviewed, and these residents indicated that they, and other residents with difficulties, have been assisted, as discretely as appropriate, to understand what they need to understand.

Finding: The agency has shown compliance with this Standard.

Standard 115.234: Specialized training: Investigations

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

115.234 (a)

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

115.234 (b)

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

115.234 (c)

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

115.234 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

Exceeds Standard (*Substantially exceeds requirement of standards*)

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

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.

Clover House, Inc., and TDCJ policies require that investigators are trained in conducting sexual abuse investigations in confinement settings. At this time, Clover House, Inc., has 4 trained sexual abuse/sexual harassment investigators. Clover House, Inc., policy mirrors TDCJ policy in requiring that whatever agency does investigations maintains documentation showing that investigators have completed the required training.

Analysis: Evidence, including documentation submitted and considered for compliance with this Standard, includes: interviews with investigative staff; training policy for investigative staff; investigator training curriculum; and documentation that agency investigators have completed required training.

Findings: The agency has shown compliance with this Standard.

Standard 115.235: Specialized training: Medical and mental health care

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

115.235 (a)

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

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

115.235 (b)

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

115.235 (c)

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

115.235 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners employed by the agency.) Yes No NA
- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.) Yes No NA

Auditor Overall Compliance Determination

- 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.

Clover House, Inc., has a policy related to the training of medical and mental health practitioners. All medical and mental health care practitioners who may work with victims of sexual abuse are to be properly trained. Although medical and mental health services will probably be provided offsite, the training for any that work in the facility 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. Clinical staff at Clover House are employed to provide treatment for substance dependence, rather than for mental health. These staff are trained as mental and medical staff would be trained as per this Standard.

Analysis: Evidence, including documentation submitted and considered for compliance with this Standard, includes policy AM 4 & 5; interviews with trained clinical staff; documentation that clinical staff have completed training; and training curriculum.

Finding: The agency has shown compliance with this Standard.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.241: Screening for risk of victimization and abusiveness

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

115.241 (a)

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

115.241 (b)

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

115.241 (c)

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

115.241 (d)

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

115.241 (e)

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

115.241 (f)

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

115.241 (g)

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

115.241 (h)

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

115.241 (i)

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

Auditor Overall Compliance Determination

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

Clover House, Inc., 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 to 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.

Analysis: Evidence, including documentation submitted and considered for compliance with this Standard, includes policy AM 4.6 and 10 resident screenings and reassessments (when applicable) regarding randomly selected residents. Interviews were conducted with the staff who complete the risk screening and reassessments, other staff and administrators, and randomly selected residents.

Finding: The agency has shown compliance with this Standard.

Standard 115.242: Use of screening information

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

115.242 (a)

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

115.242 (b)

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

115.242 (c)

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

115.242 (d)

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

115.242 (e)

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

115.242 (f)

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

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

Auditor Overall Compliance Determination

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

Information from the risk screening required by § 115.241 is to be 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. Clover House, Inc., makes housing and program assignments for transgender or intersex residents in the facility on a case-by-case basis. A transgender or intersex resident's own view with respect to safety is given serious consideration. Transgender and intersex residents are given the opportunity to shower separately from other residents. Policy states that the agency shall not place lesbian, gay, bisexual, transgender, or intersex residents in dedicated units.

Analysis: 10 randomly selected resident files were reviewed, during the Pre-Audit process, for compliance with this Standard, and the agency appeared to be compliant, since all provisions of this Standard were addressed in the forms used. However, when the audit team arrived at the facility for the on-site audit, the agency seemed unable to identify residents for targeted interviews, according to the way they answered screening questions. They only had certain residents identified, due to obvious risks, such as age or relatively debilitating medical conditions. Also, they have a long-standing method of identifying residents who score as high-risk. They seemed unable to produce, for example, a list of residents who had been sexually abused in their past, or who had disabilities relating to mental health issues. This prompted several discussions and research into the source of the problem, culminating in an action plan agreed to during the exit briefing, regarding steps that could be taken in the 30 days after the on-site audit. The information regarding residents that could be used to protect them, that was known to the agency, but which was not available when needed, was secure with clinical staff, who have been keeping information under a very tight confidentiality practice. A protocol was developed, which continues to maintain the tightest confidentiality regarding diagnoses and specific details, but

which will notify administrators in charge of approving housing, work, bed, programming, and education assignments regarding the pertinent information (kept in general terms) that may be needed to make decisions to maximize the safety of residents. The “Client Potential Risk Factor Review” was developed and implemented by the Clinical Director within one week after the on-site audit. Examples of the use of this new tool were provided to the audit team to verify practice. This allowed for additional weeks of practice, and feedback, prior to the PREA Audit Final Report.

Otherwise, evidence utilized to determine compliance includes interviews with the PREA Coordinator, staff responsible for performing risk screenings, and policy AM 4.6. Also, interviews with other staff and random residents generally indicated that screenings and reassessments are performed as required, and that confidentiality was protected appropriately.

Finding: The agency has shown compliance with 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.

Clover House, Inc., 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. They are always free to talk to any staff they choose, or to call the Administration Office. Also, 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. Clover House, Inc., provides their residents with private use of phones and provides multiple outside reporting numbers, which are posted liberally around the housing units: Safe Prison's Program Management Office, PREA Ombudsman Office, and the Office of Inspector General. 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.

Analysis: Evidence, including documentation submitted and considered for compliance with this Standard, includes: Policy AM 4.7, procedures, postings, information given in staff training and resident education, and the Resident Handbook. Interviews with randomly selected staff and residents indicate that residents know they can report. Staff interviewed say they can take reports and know how to instruct and assist residents to make reports.

Finding: The agency has shown compliance with this Standard.

Standard 115.252: Exhaustion of administrative remedies

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

115.252 (a)

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

115.252 (b)

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

115.252 (c)

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

115.252 (d)

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

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

115.252 (e)

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

115.252 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) Yes No NA
- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.)
 Yes No NA
- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) Yes No NA
- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)
 Yes No NA
- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) Yes No NA
- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) Yes No NA

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

115.252 (g)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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.

Clover House, Inc., 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 require 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.

If the agency files for an extension, the agency notifies the resident in writing, including notice of the date by which a decision will be made. Residents may be assisted in filing requests for administrative remedies relating to allegations of sexual abuse, by third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, who also may 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.

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 emergency grievances require an initial response within 48 hours and a final agency decision within five days. 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.

Analysis: Evidence, including documentation submitted and considered for compliance with this Standard, includes policy AM 4.7, grievance procedures, postings, information given in staff training and resident education, and the Resident Handbook. In the past 12 months, there have been no grievances filed that alleged sexual abuse. However, interviews indicate that staff and residents understand this process.

Finding: The agency has shown compliance with this Standard.

Standard 115.253: Resident access to outside confidential support services

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

115.253 (a)

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

115.253 (b)

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

115.253 (c)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Clover House, Inc., provides residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers for victim advocacy and rape crisis organizations, and by enabling reasonable communication between residents and these organizations in as confidential a manner as possible. Prior to providing residents with access to outside support services, the facility informs residents 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. Although mental health services are provided off-site, interviews indicate that the in-house clinicians addressing chemical dependency issues are well-versed regarding confidentiality, and that these clinicians understand their obligations to reveal the limits of confidentiality, even when clients may be accessing services elsewhere. Clover House provides information about the Crisis Center: 866-627-4747. They also provide contact information for Odessa Police Department, TDCJ Corrections Division Safe Prisons Management Office, TDCJ PREA Ombudsman Office, and the Office of the Attorney General.

Analysis: In addition to the site review and the review of postings and other notices provided for residents' review, with the information mentioned above, evidence indicating compliance with this Standard includes Policy AM 4.7. Resident handbooks, other written materials, and MOUs were also reviewed. The audit team called the Crisis Center's 24-hour hotline and confirmed the MOU and services provided through that agreement, including working with MCH (Medical Center Hospital) for SANE exams. The audit team also called the MCH ER and confirmed their 24/7 services and their ongoing relationship with the Crisis Center.

Finding: The agency has shown compliance with this Standard.

Standard 115.254: Third-party reporting

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

115.254 (a)

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

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

Auditor Overall Compliance Determination

Exceeds Standard (*Substantially exceeds requirement of standards*)

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

Does Not Meet Standard (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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Clover House, Inc., does provide a method to receive third-party reports of resident sexual abuse or sexual harassment. In conjunction with TDCJ, the agency publicly distributes information on how to report resident sexual abuse or sexual harassment on behalf of residents.

Analysis: During interviews, the audit team verified that staff and residents are instructed about third-party reporting. The site review and internet research verified that the information is available publicly. Residents indicated they know about third-party reporting, and that they know how to do it. Documentation submitted and considered for compliance with this Standard includes policy AM 4.7 (page 14) and the third-party reporting posters, and the information covered in training and education.

Finding: The agency has shown compliance with 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

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Clover House, Inc., 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 to 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.

Analysis: Staff and residents interviewed indicate that reporting requirements and methods are known throughout the facility. Residents, as well as staff, state they have not observed any sexual abuse or harassment at this facility. Policy AM 4.8(a) was reviewed, and the Director/PREA Coordinator and clinical staff were also interviewed regarding this Standard.

Finding: The agency has shown compliance with 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.

When Clover House, Inc., 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 during which staff would have to take appropriate measures.

Analysis: Evidence, including documentation submitted and considered for compliance with this Standard, includes policy AM 4.6 (page 12) and verification that risk of imminent sexual abuse is

covered in staff trainings. Interviews regarding this Standard were conducted with the Director (who is also the PREA Coordinator), randomly selected staff, and clinical staff.

Finding: The agency has shown compliance with 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.

Clover House, Inc., 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. Agency policy requires the facility head to provide such notification as soon as possible, but no later than 72 hours after receiving the allegation. 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.

Analysis: Agency policy regarding this Standard is found in AM 4.8 (page 15). Interviews with the Director/PREA Coordinator indicate a full understanding of the spirit and letter of this Standard and policy. Since all residents are from TDCJ, she would notify TDCJ right away about any allegation, then report directly to the head of the facility in which the allegation occurred. The PAQ and interviews indicate that no allegations have been received in the past 12 months applicable to this Standard.

Finding: The agency has shown compliance with this Standard.

Standard 115.264: Staff first responder duties

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

115.264 (a)

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

115.264 (b)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Clover House, Inc., 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. 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.

Analysis: Evidence, including documentation submitted and considered for compliance with this Standard, includes policy AM 4.8 (a), staff training curriculum, and the Coordinated Response Plan (CRP). In addition, interviews with randomly selected staff were performed. In the past 12 months, there have been no allegations that a resident was sexually abused, so the auditor was not able to review documentation of first responder duties actually performed. First Responder duties are printed on the back of staff name tags, and interviews indicate that staff, including clinical staff, and administrators understand their first responder duties.

Finding: The agency has shown compliance with this Standard.

Standard 115.265: Coordinated response

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

115.265 (a)

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

Auditor Overall Compliance Determination

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

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

Instructions for Overall Compliance Determination Narrative

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The agency has developed 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.

Analysis: Evidence, including documentation submitted and considered for compliance with this Standard, includes the Coordinated Response Plan and related policies, and the First Responder Duties. Also pertinent are the trainings received by staff, and interviews with administrators who demonstrate an understanding of the CRP.

Finding: The agency has shown compliance with this Standard.

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

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

115.266 (a)

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

115.266 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

Instructions for Overall Compliance Determination Narrative

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The agency has not entered into any collective bargaining agreement. The facility has the ability and authority to protect residents from contact with abusers.

Analysis: Interviews with staff and administrators verify that there is no Collective Bargaining Agreement, or other agreement, that would restrict the ability of the agency to protect residents. This is consistent with HR policies and the contract with TDCJ.

Finding: The agency has shown compliance with 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

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Clover House, Inc., has a policy to protect all residents and staff who report sexual abuse or sexual harassment, or who cooperate with sexual abuse or sexual harassment investigations, from retaliation by other residents or staff. The agency’s PREA Coordinator and HR Director will monitor for retaliation to assure full compliance with this Standard. According to policies, and echoed in interviews, in order to see whether there have been any alterations that might indicate possible retaliation by residents and/or staff, the agency monitors the conduct and treatment of residents and staff who have reported sexual abuse, and of residents who were reported to have suffered sexual abuse. Policies and interviews also indicate they will utilize shift supervisors, as well, in monitoring conduct and treatment for 90 days, or longer if indicated, and to act promptly to remedy any retaliation. They 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. They monitor resident disciplinary reports, housing, and program changes, as well as negative performance reviews and reassignments of staff. Monitoring includes periodic status checks.

Analysis: Evidence, including documentation submitted and considered for compliance with this Standard, includes policy AM 4.8 (a) (page 16), forms, and training materials. Interviews with the PREA Coordinator and HR Director indicate a full understanding of this policy, even though no incidents of retaliation in the past 12 months are known.

Finding: The agency has shown compliance with this Standard.

INVESTIGATIONS

Standard 115.271: Criminal and administrative agency investigations

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

115.271 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).) Yes No NA
- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).) Yes No NA

115.271 (b)

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

115.271 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? Yes No
- Do investigators interview alleged victims, suspected perpetrators, and witnesses? Yes No
- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? Yes No

115.271 (d)

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

115.271 (e)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff? Yes No
- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? Yes No

115.271 (f)

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

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

115.271 (g)

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

115.271 (h)

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

115.271 (i)

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

115.271 (j)

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

115.271 (k)

- Auditor is not required to audit this provision.

115.271 (l)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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Clover House, Inc., has a written policy related to criminal and administrative agency investigations. When there are allegations of conduct that appears to be criminal, and those allegations are substantiated, those allegations are 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 for allegations that have been made by third parties and/or by anonymous reports. These investigations must be performed by investigators who have received special training in sexual abuse investigations. 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 they 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 it shall not be determined by the person's status as resident or staff. A polygraph examination is not required. Administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse; and they 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 are to be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence, and which 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 does not provide a basis for terminating an investigation.

Analysis: Evidence, including documentation submitted and considered for compliance with this Standard, includes policy AM 4.9 (pages 17-19); interview with investigative staff; and training records for 4 investigators; and training curriculum.

Finding: The agency has shown compliance with this Standard.

Standard 115.272: Evidentiary standard for administrative investigations

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

115.272 (a)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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Clover House, Inc. 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.

Analysis: Policy is found in AM 4.9, page 18. Investigators and administrators interviewed seem to understand this policy. In addition, the training provided to investigators covers evidentiary standards.

Finding: The agency has shown compliance with 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 the agency’s facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) Yes No NA

115.273 (c)

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

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

115.273 (d)

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

115.273 (e)

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

115.273 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

The agency has a policy requiring that any resident who makes an allegation that he or she suffered sexual abuse in an agency facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded, following an investigation by the agency. Also, unless the agency has determined that an allegation is unfounded, following a resident’s allegation that a staff member has committed sexual abuse against the resident, the agency/facility subsequently informs the resident 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 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 subsequently informs the alleged victim whenever the agency 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 by contractual agreement with TDCJ, all notifications to residents described under this Standard are documented.

Analysis: Evidence for compliance includes the contents of the interviews with the Director, Investigative Staff, policy AM 4.9, and the forms to be utilized for these notifications. These sources provide a triangulation of evidence consistent with the Standard.

Finding: The agency has shown compliance with 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.

Staff are subject to disciplinary sanctions, up to and including termination, for violating agency sexual abuse or sexual harassment policies. The disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are 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. Unless the activity clearly was not criminal, 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 reported to law enforcement agencies, and to any relevant licensing bodies.

Analysis: Interviews with the HR Director and the Executive Director indicate that these policies are known and will be followed. Also, interviews with staff and residents indicate a strong belief that Clover House, Inc., will not tolerate any abuse and will take appropriate actions if an incident occurs. Related policy is found in AM 4.10. According to the PAQ and interviews, there have not been any staff from the facility who allegedly violated agency sexual abuse or sexual harassment policies in the past 12 months.

Finding: The agency has shown compliance with this Standard.

Standard 115.277: Corrective action for contractors and volunteers

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

115.277 (a)

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

115.277 (b)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Clover House, Inc., 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. 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.

Analysis: Interviews and documentation provided indicate that the agency does not have contractors who work regularly in the facility, however nurses from an outside agency have been approved to enter

the facility if needed. Typically, residents obtain medical care outside the facility. The only volunteers are AA facilitators. Other services are provided in the community. Policy regarding this Standard is found in AM 4.10 (a) and in the training materials that can be provided to volunteers and contractors. 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. All materials provided and interviews conducted indicated compliance with this Standard.

Finding: The agency has shown compliance with 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)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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. Whether a resident's mental disabilities or mental illness contributed to his or her behavior is considered, as part of the disciplinary process, 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. Only upon finding that a staff member did not consent to such contact does the agency discipline residents for sexual conduct with staff. 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. The agency prohibits all sexual activity between residents, but it deems such activity to constitute sexual abuse only if it determines that the activity is coerced.

Analysis: According to the PAQ and interviews conducted at the site, there have been no findings in the past year regarding resident-on-resident sexual abuse or harassment. Evidence submitted and considered for compliance with this Standard includes Policy AM 4.10 (a) governing disciplinary sanctions for residents. The interviews with the Director, staff, and residents, indicate a belief that this Standard is understood and that it applies when abuse is alleged. The audit team verified services available in the community for residents.

Finding: The agency has shown compliance with this Standard.

MEDICAL AND MENTAL CARE

Standard 115.282: Access to emergency medical and mental health services

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

115.282 (a)

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

115.282 (b)

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

115.282 (c)

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

115.282 (d)

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

Auditor Overall Compliance Determination

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

Does Not Meet Standard (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

Clover House, Inc., resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services consistent to the provisions of this Standard. This includes 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.

Analysis: Evidence, including documentation submitted and considered for compliance with this Standard, includes interviews with Clinical Staff; Policy AM 4.11; interviews with the Crisis Center and the Medical Center Hospital ER; the Coordinated Response Plan, MOUs, and TDCJ contractual obligations.

Finding: The agency has shown compliance with this Standard.

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

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

115.283 (a)

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

115.283 (b)

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

115.283 (c)

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

115.283 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if “all-male” facility. *Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) Yes No NA

115.283 (e)

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

115.283 (f)

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

115.283 (g)

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

115.283 (h)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

Clover House, Inc., 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 as required by the provisions of this Standard. Services that cannot be provided inhouse are referred out. The Crisis Center verifies that resident victims get the same care offered to other members of the community that present for services.

Analysis: Evidence including documentation submitted and considered for compliance with this Standard include: Interviews with clinical staff at Clover House; Interviews with the Crisis Center and the Medical Center Hospital ER; Policy AM 4.11 (d); and materials provided to residents, and posted in the facility, regarding these services.

Finding: The agency has shown compliance with this Standard.

DATA COLLECTION AND REVIEW

Standard 115.286: Sexual abuse incident reviews

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

115.286 (a)

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

115.286 (b)

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

115.286 (c)

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

115.286 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? Yes No

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

115.286 (e)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Clover House, Inc. policy requires a sexual abuse incident review consistent with all the provisions of this Standard at the conclusion of every criminal or administrative sexual abuse investigation, unless the allegation has been determined to be unfounded.

Analysis: Evidence including documentation submitted and considered for compliance with this Standard includes interviews with the Director/PREA Coordinator, PREA Compliance Manager, and other members of the Incident Review Team; Policy AM 4.12 (page 21); and the form template to be

used. The auditor could not review any incident reviews since there were no investigations conducted, or indicated, in the past 12 months. Interviews indicate that the considerations required by the provisions of this Standard are considerations given to other types of incidents, and therefore expected, and in the agency culture.

Finding: The agency has shown compliance with this Standard.

Standard 115.287: Data collection

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

115.287 (a)

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

115.287 (b)

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

115.287 (c)

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

115.287 (d)

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

115.287 (e)

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

115.287 (f)

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

Auditor Overall Compliance Determination

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

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

Instructions for Overall Compliance Determination Narrative

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

Clover House uses a standardized instrument and set of definitions to collect accurate, uniform data for every allegation of sexual abuse. The standardized instrument includes the data necessary to answer all questions from the most recent version of the Survey of Sexual Victimization (SSV) conducted by the Department of Justice. They aggregate the incident-based sexual abuse data at least annually, and they maintain, review, and collect data, as needed, from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

Analysis: Since the agency had no allegations in the past 12 months, the auditor had to rely heavily on interviews on the PREA Coordinator, PREA Compliance Manager, forms that are used, and the policy review (Policy AM 4.12, pages 21-22) to verify current compliance. Other interviews, and other documentation provided, revealed no inconsistent information.

Finding: The agency has shown compliance with 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.

Clover House, Inc. 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. The annual report includes a comparison of the current year's data and corrective actions with those from prior years. The annual report provides an assessment of the agency's progress in addressing sexual abuse. The agency makes its annual report readily available to the public, once approved by the agency head. When the agency redacts material from an annual report for publication, the redactions are limited to specific materials where publication would present a clear and specific threat to the safety and security of the facility. The agency indicates the nature of material redacted, if any.

Analysis: Evidence, including documentation submitted and considered for compliance with this Standard includes: Policy AM 4.12; interviews with the Director/PREA Coordinator and the PREA Compliance Manager; Offender Protections Investigations Tracking Logs (2014-2018); PREA

Community Confinement Data Reviews for 2017 and 2018; and the Survey of Sexual Victimization (SSV) completed for 2018. The Data Review includes all provisions for this Standard. Corrective actions taken include reprinting PREA posters, resupplying Crisis Center pamphlets, cameras being repositioned, bed assignment reviews, staffing assignment reviews, and allegations from previous years being reviewed. Historically, Clover House has posted notices in visitation areas to inform the public that PREA policies and annual reports are available upon request. Although these notices are still up, the agency has recently created a website as an improved method to provide information to the public as required in Standards 115.288 and 115.289.

Finding: The agency has shown compliance with this Standard.

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.

Clover House, Inc., 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 removes all personal identifiers. The agency maintains 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.

Analysis: Evidence, including documentation submitted and considered for compliance with this Standard, includes: Policy AM 4.12 (page 22), interviews, website review, and public notices posted in visitation areas. Historically, Clover House has posted notices in visitation areas to inform the public that PREA policies and annual reports are available upon request. Although these notices are still up, the agency has recently created a website as an improved method to provide information to the public as required in Standards 115.288 and 115.289: <http://www.cloverhouseinc.com/>. The Annual Report for TDCJ is posted at https://www.tdcj.texas.gov/documents/PREA_SPP_Report_2017.pdf.

Finding: The agency has shown compliance with this Standard.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

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

115.401 (a)

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

115.401 (b)

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

- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) Yes No NA

115.401 (h)

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

115.401 (i)

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

115.401 (m)

- Was the auditor permitted to conduct private interviews with residents? Yes No

115.401 (n)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

The audit team received relevant documents, had full access to the facility, and conducted private interviews as needed.

Analysis: DOJ has established audit cycles for use in scheduling audits. Each agency is required to have 1/3 of their facilities audited during each audit year. Agencies, such as Clover House, which only operate one facility, should have their audits conducted during the first audit year of each 3-year audit

cycle. The facility was not audited during the first audit cycle. The facility's first audit was completed 03-22-2017, which is during the first year of the second audit cycle. This current audit is completed during the first year of the third Audit Cycle. This, along with the agency's compliance with the other auditing guidelines, indicates full compliance with this Standard for two audit cycles.

Finding: The agency has shown compliance with this Standard.

Standard 115.403: Audit contents and findings

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

115.403 (f)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

The previous audit is posted publicly at https://www.tdcj.texas.gov/documents/prea_report/Clover_House_2017-03-22.pdf.

Analysis: The previous PREA audit has been posted as required.

Finding: The agency has shown compliance with this Standard.

AUDITOR CERTIFICATION

I certify that:

- The contents of this report are accurate to the best of my knowledge.
- No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- I have not included in the final report any personally identifiable information (PII) about any resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

Auditor Instructions:

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

D. Will Weir

10-23-2019

Auditor Signature

Date

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

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