

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

Interim       Final

**Date of Report**    January 4, 2019

### Auditor Information

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<b>Company Name:</b> KEA Correctional Consulting LLC	
<b>Mailing Address:</b> PO Box 1872	<b>City, State, Zip:</b> Castle Rock, CO 80104
<b>Telephone:</b> 484-999-4167	<b>Date of Facility Visit:</b> August 8,9, 2018

### Agency Information

<b>Name of Agency:</b> CoreCivic		<b>Governing Authority or Parent Agency (If Applicable):</b> NA	
<b>Physical Address:</b> 10 Burton Hills Blvd.		<b>City, State, Zip:</b> Nashville, TN 37215	
<b>Mailing Address:</b> Same as Above		<b>City, State, Zip:</b> Same as Above	
<b>Telephone:</b> 615-263-3000		<b>Is Agency accredited by any organization?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
<b>The Agency Is:</b>	<input type="checkbox"/> Military	<input checked="" type="checkbox"/> Private for Profit	<input type="checkbox"/> Private not for Profit
<input type="checkbox"/> Municipal	<input type="checkbox"/> County	<input type="checkbox"/> State	<input type="checkbox"/> Federal
<b>Agency mission:</b> See report narrative.			
<b>Agency Website with PREA Information:</b> <a href="http://www.corecivic.com/security-operations/prea">http://www.corecivic.com/security-operations/prea</a>			

### Agency Chief Executive Officer

<b>Name:</b> Damon Hininger	<b>Title:</b> President and CEO
<b>Email:</b> <a href="mailto:damon.hininger@corecivic.com">damon.hininger@corecivic.com</a>	<b>Telephone:</b> 615-263-3000

### Agency-Wide PREA Coordinator

<b>Name:</b> Eric S. Pierson	<b>Title:</b> Sr. Director, PREA Programs and Compliance
<b>Email:</b> <a href="mailto:eric.pierson@corecivic.com">eric.pierson@corecivic.com</a>	<b>Telephone:</b> 615-263-6915
<b>PREA Coordinator Reports to:</b> Steve Conry, Vice President Operations Administration	<b>Number of Compliance Managers who report to the PREA Coordinator</b> 63

### Facility Information

<b>Name of Facility:</b> El Paso Transitional Center			
<b>Physical Address:</b> 1650 Horizon Blvd. El Paso, TX			
<b>Mailing Address (if different than above):</b> Same as Above			
<b>Telephone Number:</b> 915-852-1505			
<b>The Facility Is:</b>	<input type="checkbox"/> Military	<input checked="" type="checkbox"/> Private for Profit	<input type="checkbox"/> Private not for Profit
<input type="checkbox"/> Municipal	<input type="checkbox"/> County	<input type="checkbox"/> State	<input type="checkbox"/> Federal
<b>Facility Type:</b>	<input type="checkbox"/> Community treatment center	<input checked="" type="checkbox"/> Halfway house	<input type="checkbox"/> Restitution center
	<input type="checkbox"/> Mental health facility	<input type="checkbox"/> Alcohol or drug rehabilitation center	
	<input type="checkbox"/> Other community correctional facility		
<b>Facility Mission:</b> See following narrative.			
<b>Facility Website with PREA Information:</b> <a href="http://www.corecivic.com/security-operations/prea">http://www.corecivic.com/security-operations/prea</a>			
<b>Have there been any internal or external audits of and/or accreditations by any other organization?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

### Director

<b>Name:</b> Hector Melchor	<b>Title:</b> Facility Administrator
<b>Email:</b> <a href="mailto:hector.Melchor@corecivic.com">hector.Melchor@corecivic.com</a>	<b>Telephone:</b> 915-852-1505

<b>Facility PREA Compliance Manager</b>			
<b>Name:</b> Alicia Wall		<b>Title:</b> Assistant Director	
<b>Email:</b> <a href="mailto:alicia.wall@corecivic.com">alicia.wall@corecivic.com</a>		<b>Telephone:</b> 915-852-1505	
<b>Facility Health Service Administrator</b>			
<b>Name:</b> NA		<b>Title:</b> NA	
<b>Email:</b> NA		<b>Telephone:</b> NA	
<b>Facility Characteristics</b>			
<b>Designated Facility Capacity:</b> 200		<b>Current Population of Facility:</b> 149	
<b>Number of residents admitted to facility during the past 12 months</b>			825
<b>Number of residents admitted to facility during the past 12 months who were transferred from a different community confinement facility:</b>			0
<b>Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 30 days or more:</b>			108
<b>Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:</b>			149
<b>Number of residents on date of audit who were admitted to facility prior to August 20, 2012:</b>			0
<b>Age Range of Population:</b>	<input checked="" type="checkbox"/> Adults 19-72	<input type="checkbox"/> Juveniles Click or tap here to enter text.	<input type="checkbox"/> Youthful residents Click or tap here to enter text.
<b>Average length of stay or time under supervision:</b>			186 days
<b>Facility Security Level:</b>			Minimum
<b>Resident Custody Levels:</b>			Minimum
<b>Number of staff currently employed by the facility who may have contact with residents:</b>			41
<b>Number of staff hired by the facility during the past 12 months who may have contact with residents:</b>			22
<b>Number of contracts in the past 12 months for services with contractors who may have contact with residents:</b>			2
<b>Physical Plant</b>			

<b>Number of Buildings:</b> 1	<b>Number of Single Cell Housing Units:</b> 0
<b>Number of Multiple Occupancy Cell Housing Units:</b>	0
<b>Number of Open Bay/Dorm Housing Units:</b>	5
<b>Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.):</b>	
The building currently has 12 surveillance cameras monitored in the security office. Retention of video is two weeks. All five dormitory areas have surveillance to include VA hallway, recreation yards, and front building area	
<b>Medical</b>	
<b>Type of Medical Facility:</b>	NA
<b>Forensic sexual assault medical exams are conducted at:</b>	University Medical Center (UMC) of El Paso
<b>Other</b>	
<b>Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:</b>	4
<b>Number of investigators the agency currently employs to investigate allegations of sexual abuse:</b>	3

# Audit Findings

## Audit Narrative

The Prison Rape Elimination Act (PREA) on-site audit of the El Paso Transitional Center (EPTC) was conducted August 8 and 9, 2018, by K. E. Arnold from Castle Rock, CO, a United States Department of Justice Certified PREA Auditor for both juvenile and adult facilities. Pre-audit preparation included review of all materials and self reports electronically uploaded to an encrypted thumb drive and mailed to the auditor's address via United States Postal Service. The same was securely packaged.

The documentation review included, but was not limited to, Core Civic (CC) facility policies, staff training slides, completed forms regarding both staff and inmate training, MOUs, organizational chart(s), CC and Texas Department of Criminal Justice (TDCJ) PREA brochures, inmate education materials, photographs of PREA related materials (e.g. posters, etc.), executed Human Resources documents associated with relevant PREA standard(s), and staff training certifications. This review prompted several questions and informational needs that were addressed with the EPTC Director and PREA Compliance Manager (EPTC PCM). The majority of informational needs were addressed pursuant to this process.

The auditor contacted Just Detention International (JDI) to inquire as to any reports or complaints received regarding EPTC. Via e-mail, the auditor was advised there were no issues known to them regarding EPTC.

The auditor met with the Director, CC Senior Director PREA Programs, and EPTC PREA Compliance Manager (PCM) at 8:10AM on Wednesday, August 8, 2018. The auditor provided an overview of the audit process and advised all attendees the same would be facilitated in the least disruptive manner possible. Additionally, the auditor advised attendees of the tentative schedule(s) for the conduct of the audit. Between 8:30AM and 10:30AM, the auditor toured the entire facility with the Director, CC Senior Director PREA Programs, and EPTC PCM.

It is noted the rated capacity of EPTC is 200 residents and the institutional count on August 8, 2018 was 149 residents.

During the on-site audit, the Auditor was provided a conference room from which to review documents and facilitate confidential interviews with staff and residents. The auditor randomly selected (from a resident roster provided by the Director) 20 residents for on-site interviews pursuant to the Resident Interview Questionnaire. Interviewees represented all pods.

It is noted the 20 random resident interviewees were generally questioned regarding their knowledge of a variety of PREA protections and their knowledge of reporting mechanisms available to residents for

reporting sexual abuse and sexual harassment. Overall, random resident interviewees presented reasonable knowledge of PREA policies and practices. Of note, the auditor inquired as to the basis for their knowledge and several random inmates advised they had received training by EPTC staff, as well as, information gleaned pursuant to previous PREA training within State prisons and jails.

Thirteen random staff selected by the auditor from a staff roster provided by the Director, were interviewed. The Random Sample of Staff Interview Questionnaire was administered to this sample group of interviewees. Interviewees were questioned regarding PREA training and overall knowledge of the agency's zero tolerance policy, reporting mechanisms available to inmates and staff, the response protocols when an inmate alleges abuse, and First Responder duties.

The following specialty staff questionnaires were utilized during this review including:

- Agency Head
- Director
- EPTC PCM (1)
- Designated Staff Charged with Monitoring Retaliation (1)
- Incident Review Team (1)
- Human Resources (1)
- Investigator (1)
- Medical Staff (1)
- SAFE/SANE Staff- (1)
- Intake (1)
- Staff Who Perform Screening for Risk of Victimization and Abusiveness (2)
- Security and Non-Security Staff Who Have Acted as First Responders (6 Security staff and 1 Non-Security staff)
- Non-medical Staff Involved in Cross-Gender Strip or Visual Searches (1)
- Contractors Who Have Contact With Inmates (1)

The Contract Administrator interview was not conducted as EPTC does not employ staff in that capacity.

It is noted CC is the umbrella company for EPTC.

The following inmate interviews were facilitated in addition to the random inmate interviews. The interview sets are noted below:

- Disabled and Limited English Proficient Residents (5, inclusive of 1 resident with mental disabilities, 1 blind/low vision/and 1 LEP)
- Inmates Who Reported a Sexual Abuse (1)
- Transgender/Intersex(1)
- Lesbian, Gay Bisexual (1)

The auditor reviewed 10 Staff Training records and one Contractor Staff Training Record, 12 inmate files, 10 staff HR files/one contractor file, seven PREA investigative files, and other records reflected throughout the following narrative, prior to the audit, during the audit, and subsequent to completion of the same.

On August 8, 2018, the auditor was processed into the facility at the facility Front Entrance. The auditor did not note PREA third-party notification (telephonic reporting information) posted in the Front Entrance.

During the facility tour, the auditor noted PREA Hotline notification numbers were posted on walls in each area, inclusive of the Visitation Room, throughout the facility. Ethics Liaison posters (staff private reporting mechanism) were posted in the Staff Assembly Area. PREA Audit Notices were prevalent throughout the facility, inclusive of the housing units, program areas, etc. It is also noted a reminder regarding opposite gender staff announcements is painted above the doorway in each housing unit.

During the facility tour, the auditor observed, among other features, the facility configuration, location of cameras, staff supervision of residents, unit layout (inclusive of shower areas), placement of PREA posters and informational resources, security monitoring, and inmate programming.

Throughout the tour, the auditor observed numerous PREA posters in housing units, program areas, Food Service, staff offices/gathering places. Clearly, residents have access to continual education regarding PREA processes.

The auditor noted camera surveillance (24 cameras) fairly well dispersed throughout the facility, inclusive of programs and operations areas. No cameras are present in the Executive Area however, residents are always supervised by staff. It is noted entrants into the area can be tracked by camera surveillance.

In regard to camera placements, the auditor noted hallways are fairly well covered with camera surveillance. The Case Management Office is a high traffic area where staff/resident volume is significant. The same is monitored by a camera focused on the entry door and a camera located within this large room housing multiple Case Management staff.

There are no cameras in the Food Service Dining Area/Dish Room/Maintenance Area however, mirrors are strategically placed to capture movement, etc. The auditor recommends consideration be given to placement of cameras in these areas. A camera is located in the Laundry.

With respect to the five units, two cameras are wall mounted in each. The auditor's observation of coverage, as captured by Main Control Center monitors, reveals adequate monitoring capability. Bunks and lockers are strategically and uniformly placed within each unit, thereby affording optimal observation.

The auditor did note however, one urinal is exposed in Unit B and one toilet is exposed in Unit E. The auditor advised the Director either a shield or curtain is needed to address this issue.

To address this issue, the EPTC PCM will provide photographs of the corrective action to the auditor on or before October 19, 2018. The auditor will place the same in the audit file.

### **December 13, 2018 Update:**

**Photographs have been provided to the auditor validating the installation of privacy doors on the affected toilet/urinal stalls in B and E dormitories. The auditor is satisfied corrective action has been accomplished to address this matter.**

Nearly all staff offices/training rooms/file rooms, with the exception of an office used by medical staff/offices in the Administration area, are equipped with doors with windows.

The auditor noted sufficient staff making rounds throughout the housing areas, program and operational areas to effectively supervise the population.

During random conversations with Medical staff, the auditor learned forensic examinations are not facilitated at EPTC. Generally, any information related to forensic examinations is not generally received from hospital staff. As reflected throughout the report narrative, El Paso Sheriff's Department facilitates criminal investigations of sexual assault and accordingly, they would play a role in transport directives for forensic examination.

An On-site Audit Closeout meeting was facilitated on August 9, 2018 with the Director, CC Senior Director PREA Programs, EPTC Assistant Director/PCM, TDCJ Contract Monitor, EPTC Program Director, Case Management Supervisor, and QA Manager. The auditor expressed his gratitude for the hospitality displayed at the facility, as well as, staff's responsiveness during interviews, information gathering, etc. Additionally, the auditor thanked all in attendance for their diligence in terms of ensuring prompt reporting of interviewees.

While a rating is not provided during such Closeouts, the auditor complimented the Director regarding staff's general knowledge regarding PREA programs and operations. Additionally, he cited the PREA Victimization and Predator Screening process as a strength.

## **Facility Characteristics**

EPTC operates pursuant to contract with TDCJ and daily security/programmatic and PREA operations are focused primarily on CC policies, procedures, and practices. Residents, sentenced in State of Texas Courts and under Probation/Parole supervision are housed at EPTC.



The facility is located at 1650 North Horizon, El Paso, TX. Since October, 2015, the facility has been owned and operated by CC. The facility offers an alternative to jail or prison and provides furlough/residential re-entry to residents. The designed capacity for EPTC is 200 male residents. A substance abuse program is also contracted by the Texas Department of State Health Services.

On-site programs and services include substance abuse education, life skills, job readiness and development, as well as, case management. Some residents work within the community as approved by TDCJ officials.

The CC Mission Statement reads as follows.

We help government better the public good through:

**Core Civic Safety** - We operate safe, secure facilities that provide high quality services and effective re-entry programs that enhance public safety.

**Core Civic Community** - We deliver proven and innovative practices in settings that help people obtain employment, successfully reintegrate into society, and keep communities safe.

**Core Civic Properties** - We offer innovative and flexible real estate solutions that provide value to government and the people they serve.

## Summary of Audit Findings

**Number of Standards Exceeded:** 3. 115.231, 115.232, and 115.288

Pursuant to the PAQ, the Director self reports 13 staff (100%), who may have contact with residents, were trained or retrained in PREA requirements. Between trainings, the agency provides employees, who may have contact with residents, with refresher training about current policies regarding sexual abuse and sexual harassment during staff meetings. Employees who may have contact with residents receive PREA training on an annual basis.

Pursuant to the auditor's follow-up with the Director, he has learned thirteen staff had been trained or retrained in PREA requirements as of the date of PAQ completion. He reports all staff been trained or retrained at this point.

Twelve of the 13 random staff interviewees relate they received the afore-mentioned training, minimally, during Pre-Service or Annual In-Service PREA training. One interviewee relates she did not receive training regarding one of the 10 training topics articulated in 115.231(a).

The auditor's review of the previously referenced 10 random staff training files reveals five staff received Annual PREA Refresher training. Of note, the remaining five staff are new hires during calendar year 2018 and are not yet due for Annual PREA Refresher training.

As standard provision 115.231(c) requires additional PREA training every two years, the auditor finds EPTC exceeds the standard based on the provision of annual PREA training.

115.232 The auditor notes the standard is silent regarding refresher training. The auditor's review of one contract employee training file reveals receipt of annual In-Service PREA training. Since annual In-Service PREA training is provided to all EPTC contractors, the auditor finds EPTC to exceed compliance expectations as applied to 115.232.

115.288 The Agency Head interviewee advises CC accesses information from several sources, using incident-based sexual abuse data to assess and improve sexual abuse prevention, detection, and response policies, practices, and training. Specifically, he advises that a 5-1 Incident Reporting System is implemented wherein incidents and reports are, minimally, reviewed by Corporate and designated facility staff within a 24-hour period. Monthly, a report of PREA related incidents details frequency and location(s) of incidents within the facility, amongst other criteria. Pursuant to this procedure, Corporate and facility staff collaborate to diagnose any PREA-related issues, concerns, etc. These proactive steps, in addition to SART review findings and continual monitoring of data, are utilized to attain optimal efficiency in terms of sexual safety of inmates at CC facilities.

In view of the above, the auditor finds EPTC to exceed compliance expectations with respect to 115.288. This procedure is representative of CC's commitment and zeal in terms of enhancement of inmate sexual safety within facilities.

**Number of Standards Met:** 36

See individual narratives for each standard.

**Number of Standards Not Met:** 0

115.217 Of note, the auditor's review did not result in discovery of the three questions being asked as part of the staff promotion process. In the one promotion, a 14-2CC-H was not completed. Accordingly, the auditor finds EPTC to be non-compliant with 115.217(a).

As reflected in the narrative for 115.217(a), the 14-2CC-H, bearing the question regarding sexual harassment, was not present for the one staff member who had been promoted. Accordingly, the auditor finds EPTC to be non-compliant with 115.217(b).

To ensure EPTC is compliant with 115.217 (a) and (b), the auditor imposes a 180-day corrective action period. While April 6, 2019 is the maximum corrective action completion date, the auditor may terminate the period earlier upon satisfaction practices are institutionalized.

Accomplishment of institutionalization will be demonstrated by submission of all 14-2CC-H forms, related to promotions only, to the auditor for at least the next 90 days. The EPTC PCM will include HR document(s) reflecting the date of promotion for each affected employee and the position from which promoted, as well as, the position to which the employee was promoted. The target date for completion of this task is January 5, 2019.

To ensure this practice is completed henceforth, the EPTC PCM will provide refresher training to the HR Manager to ensure understanding. This task may be accomplished pursuant to provision of a memorandum to the HR Manager, articulating policy and PREA provision requirements in this regard. The EPTC PCM will discuss the substance of the memorandum with the HR Manager, securing her signature and date on the document. If this option is implemented, a copy of the signed and dated document will be forwarded to the auditor for inclusion in the audit file.

115.253 While policy addresses this provision, the auditor has found no method of advising residents as to monitoring of communications with outside support services and mandatory reporting rules. Accordingly, the auditor finds EPTC to be non-compliant with 115.253(b).

In view of the above, corrective action is required to address this provision. Corrective action must be completed within 180 days of the date of this report or on or before April 6, 2019. The auditor can close the corrective action period prior to this date if he is convinced the practice is institutionalized.

To attain compliance with 115.253(b), the EPTC PCM will collaborate with Corporate staff, developing posters to be hung throughout the facility, addressing the parameters of confidentiality and mandatory reporting related to communication with assistance services. While every specific scenario cannot be brainstormed and captured on one poster, general information can be provided to alert residents regarding service provider obligations to report. Additionally, the EPTC PCM will capture the information provided on the poster, transferring the same to the Resident Handbook. With this strategy, residents will readily have access to the requisite information immediately upon Intake. The EPTC PCM will forward copies of the above to the auditor for review and inclusion in the audit file.

In addition to the above, this information will be included in the Orientation presentation. Accordingly, the Orientation lesson plan must be modified to address the same. The EPTC PCM will forward a copy of the amended plan to the auditor for inclusion in the record.

Finally, staff stakeholders must be notified regarding this information. Accordingly, a memorandum can be developed, articulating the parameters as referenced above, and distributed to the Director, EPTC PCM, Quality Manager, PREA Investigator, all Case Management staff, and any other stakeholders. A copy of the memorandum, inclusive all stakeholders' signatures and date(s) of receipt, will be forwarded

to the auditor for inclusion in the record. In the alternative, the EPTC PCM can develop a training syllabus and forward the same to the auditor, inclusive of training documents reflecting staff completion of the training.

115.283 CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 25, sections 4(c and d) partially address 115.283(a). Specifically, forensic examinations are addressed however, there is no reference to historical sexual assaults that may have occurred in any prison, jail, lockup, or juvenile facility.

Similarly, there are no policy provisions regarding mental health follow-up in such situations. Provisions 115.283(f) and (h) are also absent policy references, as well as, guidance as to how facility staff accomplish such tasks. As an example, given the fact there are no mental health providers on staff at EPTC, how are referrals for mental health evaluations of resident-on-resident sexual abusers accomplished and is there a monitoring process to facilitate the same? See 115.283(h).

In view of the above, the auditor finds EPTC to be non-compliant with 115.283. Accordingly, EPTC will be subject to a 180-day corrective action period, concluding on or about April 6, 2019. Of note, this finding can be closed prior to conclusion of the maximum corrective action period at the auditor's discretion.

During the corrective action period, the EPTC PCM and Director will develop policy to address 115.283(a), as well as, the other afore-mentioned standard provisions. Policy formulation must be accomplished in accordance with CC guidelines. Subsequent to completion of the policy or addendum to CC Policy 14.2 CC, the same will be forwarded to the auditor for review.

Upon approval by the auditor and in accordance with CC policy, practice, and procedure, the policy will be institutionalized pursuant to training of relevant stakeholders. A copy of the lesson plan and signed/dated copies of relevant training certifications bearing the "I understand" caveat will be forwarded to the auditor for retention in the EPTC audit file.

115.264 While the auditor does not find sufficient basis to find EPTC non-compliant with 115.264 based on the issue and evidence noted in the narrative for 115.264, there is cause to re-train staff regarding the same. As all staff receive the same First Responder training, refresher training appears to be an appropriate remedy.

In view of the above, the EPTC PCM will ensure all staff receive training regarding the four steps to be employed by First Responders, emphasis added relative to "requesting" the victim to refrain from destroying physical evidence. Of note, First Responder refresher training must be completed on or before January 5, 2019.

The EPTC PCM will provide a roster of all staff to the auditor and he will randomly select staff names. The EPTC PCM will provide training certifications substantiating provision of the relevant training for each selectee. Additionally, the EPTC PCM will provide a copy of the training syllabus to the auditor.

The auditor did note however, one urinal is exposed in Unit B and one toilet is exposed in Unit E. The auditor advised the Director either a shield or curtain is needed to address this issue.

To address this issue, the EPTC PCM will provide photographs of the corrective action to the auditor on or before October 19, 2018. The auditor will place the same in the audit file.

## 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

Pursuant to the PAQ, the Director self reports the agency has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment in facilities it operates directly or under contract. The Director further self reports the facility has a written policy outlining how it will implement the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment.

The policy does include sanctions for those found to have participated in prohibited behaviors. The policy also includes a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents.

Core Civic (CC) Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 1-34 addresses 115.211(a).

Pursuant to the PAQ, the Director self reports the agency employs or designates an upper-level, agency-wide PREA Coordinator who has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its community confinement facilities. The Director reports the CC PREA Coordinator (CCPC) is in the agency's organizational structure and the auditor verified the same pursuant to review of the CC Organizational Chart. It is also noted an EPTC PREA Compliance Manager (PCM) facilitates the day-to-day PREA program and operations at EPTC.

The EPTC PCM interviewee asserts she feels she has sufficient time to manage all PREA- related responsibilities. As a member of the EPTC Sexual Abuse Response Team (SART), she is able to effectively track sexual abuse related issues. She follows-up regarding PREA- related investigations, makes continual rounds to assess the effectiveness of PREA programs and operations, assesses camera surveillance needs/blind spots within both facilities, and she follows up regarding SART recommendations.

The auditor's review of the EPTC Organizational Chart reveals the EPTC PCM reports directly to the Director. The Senior Director, PREA Programs and Compliance, is designated as the CCPC pursuant to the CC Organizational Chart. According to the auditor's review of the CC Organizational Chart, the CCPC reports to the Vice President, Operations Administration.

The auditor finds EPTC to be substantially compliant with 115.211.

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

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

### **115.212 (a)**

- If this agency is public and it contracts for the confinement of its residents with private agencies

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

#### 115.212 (b)

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

#### 115.212 (c)

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

#### Auditor Overall Compliance Determination

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

Pursuant to the PAQ, the Director self reports CC and EPTC do not contract with other facilities or companies to house residents designated for confinement at EPTC.

Accordingly, the auditor finds EPTC to be substantially compliant with 115.212.

### Standard 115.213: Supervision and monitoring

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

#### 115.213 (a)

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



- Does the agency document for each facility a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?  
X  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the physical layout of each facility in calculating adequate staffing levels and determining the need for video monitoring? X  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the composition of the resident population in calculating adequate staffing levels and determining the need for video monitoring? X  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the prevalence of substantiated and unsubstantiated incidents of sexual abuse in calculating adequate staffing levels and determining the need for video monitoring? X  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration any other relevant factors in calculating adequate staffing levels and determining the need for video monitoring? X  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.)  
X  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? X  Yes  No
- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to prevailing staffing patterns? X  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? X  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? X  Yes  No

#### Auditor Overall Compliance Determination

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



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

Pursuant to the PAQ, the Director self reports the agency develops and documents a staffing plan that provides for adequate levels of staffing and where applicable, video monitoring, to protect residents against sexual abuse. The Director self reports the average daily number of residents since the last PREA audit and the number on which the staffing plan is predicated is 200 residents.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 9, section D(1 and 2)(a-d) addresses 115.213(a).

The auditor's review of the EPTC Annual Staffing Plan Assessment dated October 19, 2017 reveals substantial compliance with 115.213. The document addresses all requisite areas as prescribed in 115.213(a) and is signed and dated by the EPTC PCM, the facility Director, CCPC, and the Vice President Correctional Programs (VPCP).

The Director relates the staffing plan must meet established state staff-resident ratios. Taken into consideration is the question of whether staff can sufficiently supervise each area of the facility. Security rounds are increased in areas where "blind spots" are prevalent. Recreation security rounds also account for perimeter checks.

In regard to the composition of the resident population, the 100% male population requires at least one male Resident Monitor on each shift. The number of gang members and/or wannabes housed at EPTC are a distinct consideration in crafting the staffing plan. The ability to safely monitor all residents, inclusive of the LGBTI population, is likewise a distinct consideration. Increases in sexual abuse/harassment cases from year to year are also considerations for additional staffing or video surveillance requests. Changes in resident security classifications and criminal history are also monitored to assess any additional staffing plan needs. Reallocation of existing resources is also a significant tool in terms of management of the resident population from a PREA perspective.

If any additional relevant factors present themselves, the same likewise receive consideration.

According to the EPTC PCM, she assesses the physical plant (staffing plan preparation) by evaluating blind spots. She questions whether staff can effectively monitor residents at any point throughout the facility (in other words, cradle to grave). In regard to the composition of the resident population, gang affiliations (inclusive of wannabes), resident interactions (inclusive of LGBTI) within the population, medical/mental health issues amongst the population, and sex offender interactions with other residents, are considerations with respect to staffing plan development.

With respect to the prevalence of substantiated and unsubstantiated incidents of sexual abuse, assessment of locations at which sexual abuse incidents occurred are closely assessed. The operative question is "Do we need increased staffing or visual monitoring to address the issue?" A

drastic increase in incidents warrants increased evaluation of staffing effectiveness and circumstances surrounding the incident(s).

In terms of other relevant factors, cultural and language barriers factor into the conversation regarding staffing considerations.

Pursuant to the PAQ, the Director self reports in circumstances where the staffing plan is not complied with, the facility documents and justifies all deviations from the plan. According to the Director's self report in the PAQ, there were no instances of deviation from the staffing plan during the last year.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 9, section D(3) addresses 115.213(b).

The Director asserts the Operations Supervisor reviews the staffing plan on a daily basis to ensure coverage. Accommodations are made to offset vacancies, ensuring requisite post(s) are filled in accordance with TDCJ contractual expectations and the PREA Staffing Plan. Additionally, a weekly report (HR) is generated to assess staffing/needs. Monitor IIIs also assess coverage (real-time) on a daily basis. The facility does document all instances of non-compliance with the staffing plan.

Pursuant to the PAQ, the Director self reports at least once every year, the facility reviews the staffing plan to see whether adjustments are needed to:

The staffing plan;  
Prevailing staffing patterns;  
The deployment of video monitoring systems and other monitoring technologies; or  
The allocation of facility/agency resources to commit to the staffing plan to ensure compliance with the staffing plan.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 9, section D(5)(b)(i-iii) and page 10, section D(5)(b)(iv) address 115.213(c).

The EPTC PCM asserts she hasn't been in the role of PCM for one year as of this writing. Accordingly, she has not yet been consulted.

The auditor finds EPTC to be substantially compliant with 115.213.

## **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?  
X  Yes  No

#### 115.215 (b)

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

#### 115.215 (c)

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

#### 115.215 (d)

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

### Auditor Overall Compliance Determination

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

Pursuant to the PAQ, the Director self reports cross-gender strip searches or cross-gender visual body cavity searches of the anal or genital opening are not conducted at EPTC. The Director further self reports 0 strip or cross-gender visual body cavity searches of residents were conducted at EPTC during the last 12 months.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 14, section K(1)(a) addresses 115.215(a). Exigent circumstances are defined in this policy provision, as well as, the specifics of provision requirements.

In regard to urgent circumstance(s) that may warrant a cross-gender strip search or visual body cavity search, the female non-medical staff involved in cross-gender strip or visual searches interviewee asserts female staff cannot strip search or conduct a visual body cavity search of a male resident at EPTC. This is consistent with the Director’s PAQ statement above and the auditor’s random staff interview findings during the facility tour.

Pursuant to the PAQ, the Director self reports the facility does not permit cross-gender pat-down searches of female residents, absent exigent circumstances. The Director further self reports the facility does not restrict female resident's access to regularly available programming or other outside opportunities in order to comply with this provision. In the past 12 months, no female pat-down searches were conducted by male staff.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 14, section K(1)(b) addresses 115.215(b). Exigent circumstances are defined in this policy provision, as well as, the specifics of provision requirements.

Of note, based on the auditor's observations and conversations with staff during the tour, female residents are not housed at EPTC. Accordingly, the auditor finds 115.215(b) to be not-applicable to EPTC.

Pursuant to the PAQ, the Director self reports facility policy requires all cross-gender strip searches and cross-gender visual body cavity searches be documented. Policy, as reflected in the following sentence, would be applicable in such circumstances.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 14 and 15, section K(1)(c) addresses 115.215(c).

Pursuant to the PAQ, the Director self reports the facility has implemented policies and procedures that enable resident(s) 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 cell checks (this includes viewing via video camera). The Director further self reports policies and procedures require staff of the opposite gender to announce their presence when entering a resident housing unit.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 15, section K(5 and 6) addresses 115.215(d). This policy provision addresses the requirements of the provision.

During the facility tour, the auditor observed the following painted above housing unit entry doors:

"Opposite Gender Must Announce Upon Entry".

Additionally, the auditor noted female staff clearly and audibly announce "Female" upon entry into each housing unit.

Sixteen of the 20 random resident interviewees assert female staff announce their presence when entering their housing area. With respect to the remaining four interviewees in this group, they assert female staff announce their presence most of the time when entering their housing area. Eighteen of the 20 random resident interviewees assert they and other residents are never naked, in full view of female staff (not including medical staff such as doctors, nurses), when showering, toileting, or changing clothing. With respect to the two remaining interviewees in this group, one asserts such observation occasionally occurs when resident(s) are in the shower and the other resident asserts such observation occasionally occurs when resident(s) are toileting.

All 13 random staff interviewees assert female staff announce their presence when entering a housing unit that houses residents of the opposite gender. Similarly, all interviewees assert residents are able to dress, shower, and toilet without being viewed by staff of the opposite gender.

Pursuant to the PAQ, the Director self reports the facility has a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. According to the Director, no such searches were facilitated during the last 12 months.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 15, section K(2) addresses 115.215(e).

All 13 random staff interviewees assert the facility prohibits staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. All interviewees were aware of the relevant policy.

The transgender resident interviewee asserts he has not been strip searched for the sole purpose of determining genital status.

Pursuant to the PAQ, the Director self reports 100% of all security staff have received training on conducting cross-gender pat-down searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 7, section b(i) addresses 115.215(f).

The auditor's review of PAQ training logs dated May 23 (four Security staff) reveals they received training regarding cross-gender viewing and searches.

All 13 random staff interviewees assert the agency has a policy to train all staff to conduct cross-gender pat-down searches and searches of transgender/intersex residents in a professional and respectful manner. Interviewees assert the training was presented in a video format (minimally) and some assert a live staff-to-staff demonstration ensued.

It is noted all 10 randomly reviewed employee training files reveal staff receipt of this training.

In view of the above, the auditor finds EPTC to be substantially compliant with 115.215.

## **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? X  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? X  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? X  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? X  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? X  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.) X  Yes  No
- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? X  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? X  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? X  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? X  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? X  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? X  Yes  No
- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? X  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?

X  Yes    No

### Auditor Overall Compliance Determination

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

Pursuant to the PAQ, the Director self reports the agency has established procedures to provide disabled residents 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 13, section I(5) addresses 115.216(a).

According to the Agency Head interviewee, the agency has established procedures to provide residents with disabilities and residents who are Limited English Proficient (LEP) 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. Specifically, Language Line is used, when necessary, to communicate with LEP residents. Generally speaking, staff translators can also be used. TTY units are available in every facility and Braille is available in some facilities.

Four of the five Disabled and Limited English Proficient resident interviewees advised the facility provides information about sexual abuse and sexual harassment that they are able to understand. Of note, one of these interviewees asserts he is blind and was not provided information about sexual abuse and sexual harassment in a format he was able to understand. While the interviewee asserts he was provided the PREA video and brochures/Resident Handbook, he asserts he did not alert staff at Intake that he was blind.

Despite the information conveyed in the last few sentences articulated above, the auditor is convinced the practice is institutionalized. While the resident, in question, was provided information to facilitate his understanding of the PREA program at EPTC, the auditor requested the Director to ensure he is re-educated.



Pursuant to the PAQ, the Director self reports the agency has established procedures to provide 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 14, section I(5)(a and b) addresses 115.216(b).

The auditor's review of the Language Line Interpreter Services contract reveals substantial compliance with 115.216(b).

The LEP interviewee asserts the facility provided information about sexual abuse and sexual harassment that he is able to understand. A staff interpreter translated during the interview.

Pursuant to the PAQ, the Director self reports agency 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, or the investigation of the resident's allegations. The Director further self reports the facility documents the limited circumstances in individual cases where resident interpreters, readers, or other types of resident assistants are used. Finally, in the last 12 months, there were no instances where resident interpreters, readers, or other types of resident assistants have been used and it was not the case that an extended delay in obtaining another interpreter could compromise the resident's safety, the performance of first response duties, or the investigation of the resident's allegations.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 14, section I(5)(c) addresses 115.216(c).

Five of the 13 random staff interviewees advise the agency does allow the use of resident interpreters, resident readers, or other types of resident assistants to assist disabled residents or residents with limited English proficiency when making an allegation of sexual abuse or sexual harassment. All five of the interviewees were able to cite a circumstance under which the above would be appropriate. Of note, the auditor used a mock scenario (involves an LEP resident victim) to elicit responses from interviewees.

All 13 random staff interviewees assert, to the best of their knowledge, resident interpreters, resident readers, or other types of resident assistants have not been used in relation to allegations of sexual abuse or sexual harassment.

In view of the above, the auditor finds EPTC to be substantially compliant with 115.216.

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

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

### 115.217 (a)

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

### 115.217 (b)

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

### 115.217 (c)

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

### 115.217 (d)

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

### 115.217 (e)

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

### 115.217 (f)

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

### 115.217 (g)

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

### 115.217 (h)

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

### Auditor Overall Compliance Determination

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

Pursuant to the PAQ, the Director self reports agency 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 the activity described in the above paragraph.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 5, section B(1)(a-c) addresses 115.217(a).

The auditor's random review of six Human Resource (HR) files relative to staff who have been hired during the audit period reveals the 14-2CC-H [document reflecting the requisite three questions as required in 115.217(a)] was completed prior to the hire effective date in five cases. The 14-2CC-H was completed within six days of hire in the one case that was an exception to the above.

Additionally, one contractor, who was hired prior to the last 12 months, file was reviewed with the initial hiring 14-2CC-H being absent from the file. Of note, the contractor was hired during calendar year 2013.

As a matter of procedure, the prospective employee completes the document and signs/dates the same. This process is clearly articulated in policy.

Of note, the auditor's review did not result in discovery of the three questions being asked as part of the staff promotion process. In the one promotion, a 14-2CC-H was not completed. Accordingly, the auditor finds EPTC to be non-compliant with 115.217(a).

Pursuant to the PAQ, the Director self reports agency policy requires the consideration of any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.

CC Policy 14-2CC entitled Sexual Abuse Prevention and Response, page 5, section B addresses 115.217(b).

Of note, the Form 14-2CC-H reflects a separate question as to whether a substantiated allegation of sexual harassment had been made against the individual. Additionally, the Form 3-20-2B entitled PREA Questionnaire for Prior Institutional Employers reflects the same question. Previous institutional employers are requested to complete the same however, completion cannot be forced.

As criminal record background checks do not address sexual harassment, the afore-mentioned form is the only document available to validate the 14-2CC-H.

In regard to the afore-mentioned file reviews, seven of the 10 employee files, as well as, that of the contractor, reflected no prior institutional employers. Three files, wherein there were previous institutional employers, reflect the form was forwarded to the previous employer with no response as of the dates of the on-site audit.

According to the HR interviewee, the facility does consider prior incidents of sexual harassment when determining whether to hire or promote anyone, or to enlist the services of any contractor who may have contact with residents. The afore-mentioned forms are used to ascertain whether any incidents of sexual harassment have occurred within the prospective employee's work history.

As reflected in the narrative for 115.217(a), the 14-2CC-H, bearing the question regarding sexual harassment, was not present for the one staff member who had been promoted. Accordingly, the auditor finds EPTC to be non-compliant with 115.217(b).

To ensure EPTC is compliant with 115.217 (a) and (b), the auditor imposes a 180-day corrective action period. While April 6, 2019 is the maximum corrective action completion date, the auditor may terminate the period earlier upon satisfaction practices are institutionalized.

Accomplishment of institutionalization will be demonstrated by submission of all 14-2CC-H forms, related to promotions only, to the auditor for at least the next 90 days. The EPTC PCM will include HR document(s) reflecting the date of promotion for each affected employee and the position from which promoted, as well as, the position to which the employee was promoted. The target date for completion of this task is January 5, 2019.

To ensure this practice is completed henceforth, the EPTC PCM will provide refresher training to the HR Manager to ensure understanding. This task may be accomplished pursuant to provision of a memorandum to the HR Manager, articulating policy and PREA provision requirements in this regard. The EPTC PCM will discuss the substance of the memorandum with the HR Manager, securing her signature and date on the document. If this option is implemented, a copy of the signed and dated document will be forwarded to the auditor for inclusion in the audit file.

#### **September 27, 2018 Update:**

**The Director of MUF authored a memorandum dated September 26, 2018 regarding the corrective action as cited above for 115.217(a) and (b). The HR Manger signed the memorandum on the same date and the Director has incorporated a monitoring period to ensure compliance with these provisions. The auditor will review progress on a random basis.**

**The auditor notes HR is a shared service between The El Paso Multi-Use Facility (MUF) and EPTC with the HR Manager supervised by the Director of MUF. Accordingly, this corrective action likewise applies to EPTC.**

#### **December 13, 2018 Update:**

**The EPTC PCM forwarded to the auditor seven updated 14-2CC-H forms wherein promotion applicants responded in the negative to the previously referenced questions, inclusive of substantiated allegations of sexual harassment of residents/inmates. Of note, these documents**

**represent staff who have been promoted within the last 18 months. The EPTC PCM asserts 0 staff have been promoted during the last three months.**

**The auditor finds corrective action to be sufficient to close these findings. Clearly, the HR Manager has been trained and acknowledges receipt of the training. Recent staff who have been promoted have now responded to the relevant questions. Accordingly, the auditor is closing the findings articulated for 115.217(a) and (b).**

Pursuant to the PAQ, the Director self reports agency policy requires that (a) before it hires any new employees who may have contact with residents, it conducts criminal background record checks, and (b) consistent with federal, state, and local laws, 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. The Director further self reports 22 persons were hired during the last 12 months who may have contact with residents.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 6, section B(3)(a)(i and ii) addresses 115.217(c).

According to the HR interviewee, the facility performs criminal record background checks or considers pertinent civil or administrative adjudications for all newly hired employees who may have contact with residents and all employees who may have contact with residents, as well as contractors. A criminal record background check is not conducted for internal promotions however, the same is conducted in the event of an out-of-state promotion.

As previously discussed, the auditor's review of six of the 10 afore-mentioned randomly selected employee HR Files reveals before hiring new employees who may have contact with residents, a criminal background records check is conducted. These six staff were hired during the audit period while four were hired outside that time frame. While the contractor was hired in 2013, his criminal background record check was completed prior to the date of hiring. In the six cases, criminal record background record check results were received from TDCJ prior to hiring the individual.

A discussion regarding prior institutional employer checks is addressed above in the narrative for 115.217(b).

Pursuant to the PAQ, the Director self reports agency policy requires that a criminal background record check be completed before enlisting the services of any contractor who may have contact with residents. The Director self reports there were 0 contracts for services where criminal background record checks were conducted during the past 12 months.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 6, section B(3)(b) addresses 115.217(d).

A discussion regarding the conduct of a criminal record background check for a contractor hired in 2013 is addressed in the narrative for 115.217(c).

Pursuant to the PAQ, the Director self reports agency policy requires that either criminal record background record checks are conducted at least every five years for current employees and contractors who may have contact with residents or that a system is in place for otherwise capturing such information for current employees.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 6, section B(3)(c) addresses 115.217(e).

The HR interviewee asserts the agency requires the conduct of five-year criminal background record checks. The HR interviewee provides a document for the employee to complete and she forwards the same to TDCJ for completion of the process. She uses a spreadsheet to track and manage such re-investigations.

The auditor's review of four of the 10 afore-mentioned random employee HR files, as well as, the contractor file, reveals five-year re-investigations were completed in each case, following the inception of PREA standards. These files represent the only ones applicable to the provision.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 5 section B(2) and (a) addresses 115.217(f).

The auditor is aware the equivalent of the Form 14-2CC-H is completed annually.

The auditor's review of 10 random staff HR files reveals no existence of Forms 14-2CC-H during the audit period in six cases. With respect to the remaining four files, the document is not yet due in three cases and in one case, the requisite document has been completed in accordance with the calendar year. Accordingly, the auditor finds EPTC to be non-compliant with 115.217(f).

To ensure compliance with 115.217(f), the auditor imposes a 180-day corrective action period wherein similar corrective action referenced in the narratives for 115.217(a) and (b) above is imposed. With respect to this particular finding, however, the EPTC PCM will forward two staff roster(s) [one month apart and highlighting the date of hire and promotion date(s)], to the auditor. The auditor will randomly select files and the EPTC PCM will forward copies of all 14-2CC-H forms for the auditor's review. The auditor will certify institutionalization with 115.217(f) pursuant to review of the submitted documents. Due dates for implementation and completion of this corrective action are articulated in the narratives for 115.217 (a) and (b).

### **January 1, 2019 Update:**



**The auditor's review of five randomly selected Forms 14-2CC-H reveals compliance with 115.217(f). Specifically, all have been completed by random selectees and there is no evidence of non-compliance with 115.217(f).**

**January 4, 2019 Update:**

**The auditor's review of nine additional randomly selected Forms 14-2CC-H reveals compliance with 115.217(f). All forms have been completed by random selectees and there is no evidence of non-compliance with the afore-mentioned provision.**

**In view of the above, the auditor is sufficiently convinced the process is institutionalized and accordingly, the auditor finds EPTC substantially compliant with this provision.**

According to the HR interviewee, the facility asks all applicants and employees who may have contact with residents about previous misconduct described in 115.217(a) in written applications for hiring or promotions, and in any interviews or written self-evaluations conducted as part of reviews of current employees. The Form 14-2CC-H is separate from the application however, the same is administered during both the application and interview processes. Additionally, the facility imposes upon the employee a continuing affirmative duty to disclose any such previous misconduct. Pursuant to the PAQ, the Director self reports agency policy states that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination. CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 5 section B(1)NOTE: and B(2)(b) address 115.217(g).

The auditor's review of the Form 14-2 CC-H reveals a caveat regarding material omissions relative to such misconduct, or the provision of materially false information, being the grounds for termination. This document is supposed to be signed and dated by the employee on an annual basis.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 6 section B(3)(d) addresses 115.217(h).

According to the HR interviewee, when a former employee applies for work at another institution, upon request from that institution, the facility provides information on substantiated allegations of sexual abuse or sexual harassment involving the former employee, unless prohibited by law.

In view of the above, the auditor finds EPTC to be substantially compliant with 115.217.

## **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*)

Pursuant to the PAQ, the Director self reports the facility has not acquired a new facility or made a substantial expansion or modification to existing facilities since the last PREA audit. CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 33, section V(1) addresses 115.218(a).

According to the Agency Head interviewee, when designing, acquiring, or planning substantial modifications to facilities, CC commences the process through land purchase(s) and then subsequent construction. A design team facilitates most of the preparation and standards compliance work. Architects are well versed in PREA. Lines of sight are assessed to enhance resident sexual and personal safety and camera surveillance needs to address blind spots. The same protocol is utilized with regard to expansion and renovations. Requests for changes must be approved by the design team. The design team is part of the Real Estate Group.

According to the Director, no substantial expansions or modifications to the facility have occurred since the last PREA audit.

Pursuant to the PAQ, the Director self reports the facility has installed or updated monitoring technology since the last PREA audit.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 33, section V(2) addresses 115.218(b).

Reportedly, a second camera was added to the EPTC Lobby area, enhancing observation of movement in that area and into the Administration area.

Other than the above, the Director asserts there has been no installation or updating of monitoring technology, such as video monitoring system or electronic surveillance, at EPTC since the last PREA audit.

In view of the above, the auditor finds EPTC to be substantially compliant with 115.218.

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

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

#### 115.221 (d)

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

#### 115.221 (e)

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

#### 115.221 (f)

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

#### 115.221 (g)

- Auditor is not required to audit this provision.

#### 115.221 (h)

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

#### Auditor Overall Compliance Determination

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

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

Pursuant to the PAQ, the Director self reports the facility is responsible for conducting administrative sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). The Director further self reports El Paso Sheriff's Department facilitates criminal investigations. When conducting a sexual abuse investigation, the agency investigators follow a uniform evidence protocol.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 25, section 4 and a addresses 115.221(a).

The auditor's review of the MOU between CC and the El Paso Sheriff's Department reflects substantial compliance with 115.221(a).

All six random security first responder interviewees incorrectly identified the steps necessary for first responders. Specifically, these First Responders incorrectly identified some of the steps required of First Responders. Of note, the inaccuracies identified center on requesting that the alleged victim not take any actions that could destroy physical evidence and securing the crime scene (1). Affected interviewees assert the employee must ensure, or not allow, both the victim and perpetrator to destroy physical evidence.

Of the remaining seven random staff interviewees, four of the seven also provided incorrect responses relative to First Responder duties. The incorrect responses are identical to those referenced above. The non-security staff who may act as a first responder interviewee likewise asserts the employee must ensure, or not allow, both the victim and perpetrator to destroy physical evidence.

To address the above, re-familiarization training is addressed in the narrative for 115.264. All interviewees were in possession of a CC card reflecting First Responder steps to be taken in the event of a sexual abuse allegation.

In addition to the above, two of the 13 random staff interviewees were able to correctly identify the title of the staff who facilitates administrative sexual abuse/sexual harassment investigations and agency responsible for criminal investigations of the same. The auditor did provide each affected interviewee with insight regarding these questions and he does not find the issue warrants a non-compliance finding for 115.221.

Pursuant to the PAQ, the Director self reports no youth are housed at EPTC and accordingly, 115.221(b-1) is not applicable. The Director self reports the protocol was adapted from or otherwise based on the most recent edition of the DOJ's Office on Violence Against Women publication, "A

National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents,” or similarly comprehensive and authoritative protocol developed after 2011”.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 25, section 4(b) addresses 115.221(b).

The auditor reviewed the MOU between CC and the El Paso Sheriff's Department and finds the same to be commensurate with provision expectations. The exact verbiage of the protocol is spelled out in the MOU.

The auditor notes the MOU is unsigned at this juncture. Pursuant to e-mail review, it is apparent the same is now under review by the El Paso Sheriff's Department legal section.

Pursuant to the PAQ, the Director self reports the facility offers to all residents who experience sexual abuse access to forensic medical examinations. Forensic examinations are offered without financial cost to the victim. Where possible, examinations are conducted by SAFE/SANE Nurse Examiners. When SAFE/SANE Nurses are unavailable, a qualified medical practitioner performs forensic medical examinations. All of the above is clearly articulated in an MOU with University Medical Center of El Paso. According to the Director, no forensic medical examinations were conducted during the past 12 months.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 25, section 4(c) addresses 115.221(c).

The SANE Nurse interviewee asserts she is one of six SANE nurses responsible for conducting all forensic medical examinations at UMC. She advises departmental PRNs are also SANE trained. The interviewee provides the 80-hour SANE training to staff, much of the same is clinical. SANE Nurses are available twenty-four hours per day, seven days per week and staff are on-call to ensure coverage.

The auditor's review of an MOU between UMC and CC reveals substantial compliance with 115.221(c), as well as, 115.282 and 115.283. While the MOU was unsigned at the time of the on-site audit, the e-mail thread clearly reveals on-going efforts to complete the process.

Pursuant to the PAQ, the Director self reports 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. The Director further self reports the facility does not provide a qualified agency staff member in view of an MOU between CC and the Center Against Sexual & Family Violence (CASFV).

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 25, section 4(d) an (ii) addresses 115.221(d).

The auditor's review of the afore-mentioned MOU reflects substantial compliance with 115.221(d). The auditor finds substantial evidence of facility attempts to ratify this MOU, as reflected in e-mails between EPTC and CASFV.

The EPTC PCM asserts CASFV provides Victim Advocacy (VA) services per MOU. Additionally, UMC uses a VA service. The EPTC PCM asserts she has not personally followed up regarding VA certifications and training documentation. CASFV is recognized as a credible VA service provider.

The resident who reported a sexual abuse interviewee asserts he was not allowed to contact anyone subsequent to reporting sexual abuse. He followed up, indicating there was no need to contact anyone.

Pursuant to the PAQ, the Director self reports if requested by the victim, a victim advocate accompanies and supports the victim through the forensic medical examination process and investigatory interviews and provides emotional support, crisis intervention, information, and referrals.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 25, section 4(e) addresses 115.221(e).

As reflected throughout this narrative, the EPTC PREA Investigator, among other trained PREA Investigators, facilitate administrative PREA investigations. Accordingly, the auditor finds 115.221(f) to be not applicable to EPTC.

In view of the above, the auditor finds EPTC to be substantially compliant with 115.221.

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

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

#### **115.222 (a)**

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

#### **115.222 (b)**

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

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

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

#### 115.222 (c)

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

#### 115.222 (d)

- Auditor is not required to audit this provision.

#### 115.222 (e)

- Auditor is not required to audit this provision.

#### Auditor Overall Compliance Determination

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

Pursuant to the PAQ, the Director self reports the agency ensures an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment (including resident-on-resident and staff sexual misconduct). In the past 12 months, three allegations of sexual abuse and sexual harassment were received.

It is noted the auditor reviewed seven allegations of sexual abuse received during 2018, two were criminally investigated while five were administratively investigated.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 23, section O addresses 115.222(a).

According to the Agency Head interviewee, an administrative or criminal investigation is completed for all allegations of sexual abuse or sexual harassment. Administrative investigations are completed by a



PREA trained investigator and whenever the Office of the Inspector General (OIG) arm of the partner is tasked with facilitation of criminal investigations, they are generally PREA trained pursuant to the contract.

In regard to the protocol relative to administrative/criminal sexual abuse or sexual harassment investigations, the Agency Head interviewee asserts the allegation triggers the rest of the investigative process. Medical examination and allegations the victim incurred physical harm may trigger a forensic examination as ordered by Medical professionals. The allegation is generally reported to the Director, Assistant Director, Operations Supervisor, and PCM. Notifications to the facility Investigator and/or criminal investigating agency would ensue.

The Agency Head interviewee continued, stating First Responders ensure the victim and perpetrator are separated and perpetrator, if known, is isolated. The victim would likewise remain under staff's physical supervision. Generally, physical evidence is collected by the criminal investigator in a criminal matter. If criminal, the criminal investigator determines interview status and whether the facility Investigator assists. CC investigative staff would assist the criminal investigator in any way needed, inclusive of research and preservation of camera footage, resident/staff file reviews, review of reports submitted by staff, review of resident statements (if applicable), and coordination of investigative activities. Additionally, CC officials would support prosecution efforts of both staff and residents.

The administrative investigation is generally completed by the facility Investigator. He/she employs essentially the same protocol as a criminal investigator, interviewing witnesses and assessing victim, perpetrator, witness credibility. Finally, the Investigator writes an investigative report.

The auditor's review of seven sexual abuse investigations conducted during the last 12 months, reveals substantial compliance with 115.222(a) and (b). An administrative investigation was promptly initiated/ conducted and appropriate matters were also referred to the El Paso Sheriff's Department for possible criminal investigation.

Pursuant to the PAQ, the Director self reports the agency has a policy requiring allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, including the agency if it conducts its own investigations, unless the allegation does not involve potentially criminal behavior. The Director further self reports agency policy regarding the referral of allegations of sexual abuse or sexual harassment for criminal investigation is published on the agency website. The agency documents all referrals of allegations of sexual abuse or sexual harassment for criminal investigation.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 18, section 3 and a and page 25, section 4 address 115.222(b).

The auditor's review of the CC website reveals the afore-mentioned policy is published on the website.



According to the Investigative staff interviewee, agency policy requires allegations of sexual abuse or sexual harassment be referred for investigation to the El Paso Sheriff's Department for the conduct of criminal investigations, unless the allegation does not involve potentially criminal behavior.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 25, section 4(a) addresses 115.222(c).

In view of the above, the auditor finds EPTC to be substantially compliant with 115.222.

## 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? X  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? X  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 X  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? X  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? X  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? X  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? X  Yes  No
- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? X  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*)

Pursuant to the PAQ, the Director self reports the agency trains all employees who may have contact with residents on:

- 1) Its 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) Resident's rights 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, and intersex, or gender non-conforming residents; and
- 10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 6 and 7, section C(1)(a) (i-xiii) and page 8 address 115.231(a).

The auditor's review of the CC PREA Overview Facilitator Guide reflects substantial compliance with 115.31(a). The Facilitator Guide suggests significant interactive learning between facilitator and students and content appears to be comprehensive.

Twelve of the 13 random staff interviewees relate they received the afore-mentioned training, minimally, during Pre-Service or Annual In-Service PREA training. One interviewee relates she did not receive training regarding one of the 10 training topics articulated in 115.231(a).

The auditor's review of 10 random staff training files reveals compliance with 115.231(a). PREA training is provided to all staff, who may have contact with residents, as described by random staff interviewees.

Pursuant to the PAQ, the Director self reports training is tailored to the gender of the residents at the facility. Employees who are reassigned from facilities housing the opposite gender are given additional training. The Director relates there were no staff transfers to EPTC from facilities wherein female residents are housed, during the past 24 months.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 6, section C(1)(a) and page 8, section c address 115.231(b).

The auditor's review of the afore-mentioned training curriculum reveals the same is gender-specific to male residents.

Pursuant to the PAQ, the Director self reports 13 staff (100%), who may have contact with residents, were trained or retrained in PREA requirements. Between trainings, the agency provides employees, who may have contact with residents, with refresher training about current policies regarding sexual abuse and sexual harassment during staff meetings. Employees who may have contact with residents receive PREA training on an annual basis.

Pursuant to the auditor's follow-up with the Director, he has learned thirteen staff had been trained or retrained in PREA requirements as of the date of PAQ completion. He reports all staff been trained or retrained at this point.

As standard provision 115.231(c) requires additional PREA training every two years, the auditor finds EPTC exceeds the standard based on the provision of annual PREA training.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 6, section C(1)(a) addresses 115.231(c).

The auditor's review of the previously referenced 10 random staff training files reveals five staff received Annual PREA Refresher training. Of note, the remaining five staff are new hires during calendar year 2018 and are not yet due for Annual PREA Refresher training.

Pursuant to the PAQ, the Director self reports the agency documents that employees who may have contact with residents, understand the training they received through employee signature or electronic verification.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 8, section d addresses 115.231(d).

The auditor's review of an In-Service PREA Training/Activity Attendance Roster and one signed and dated Staff Training Acknowledgment Form reflects staff's receipt of the afore-mentioned training and understanding of the same. Of note, the staff name as reflected on the afore-mentioned Training/Activity Attendance Roster is reflected on the Staff Training Acknowledgment Form.

Of note, the afore-mentioned random staff training files reveal documentation bearing the employee's signature and date (as described in the preceding paragraph), signifying their understanding of the training they received.

As noted above, the auditor finds EPTC exceeds standard expectations with respect to 115.231(c) based on provision of annual PREA training to staff who have contact with residents. Accordingly, the auditor finds EPTC to have exceeded the requirements of 115.231.

## **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? X  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

Pursuant to the PAQ, the Director self reports all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's policies and procedures regarding sexual abuse/harassment/prevention, detection, and response. The Director further self reports 100% of contractors, who have contact with residents, have been trained regarding the subject-matter referenced in the preceding sentence.

The Director further self reports four contractors provide services at EPTC who have contact with residents, and all have been trained regarding the subject-matter referenced in the preceding sentence.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 8, section 2(a) addresses 115.232(a).

According to the Contractor interviewee, he has been trained in his responsibilities regarding sexual abuse and sexual harassment prevention, detection, and response per agency policy and procedure. He relates he receives PREA training annually and he receives the same training EPTC employees receive.

According to the Director, no volunteers provide services at EPTC. A CC DVD is used to provide training to contractors, as well as, the afore-mentioned PREA Overview Facilitator Guide (referenced in the narrative for 115.231).

Pursuant to the PAQ, the Director self reports the level and type of training provided to volunteers and contractors is based on the services they provide and level of contact they have with residents. The Director further self reports contractors, who have contact with residents, have been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 8, section 2(b) addresses 115.232(b).

According to the Contractor interviewee, the PREA training consisted of a review of policies and procedures regarding response to sexual abuse incidents. Additionally, SART, reporting procedures, and first responders are discussed. The entire gamut of PREA operations in a sexual abuse scenario is also discussed. The interviewee also asserts he has been notified of the agency's zero tolerance policy on sexual abuse and sexual harassment, as well as, informed about how to report such incidents.

The auditor's review of a PAQ Training Activity Enrollment/Attendance Roster reflects two contractors participated in In-Service PREA training on September 6, 2017.

Pursuant to the PAQ, the Director self reports the agency maintains documentation confirming that volunteers/contractors understand the training they have received.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 8, section 2(c) addresses 115.232(c).

The auditor's review of two contractor Training Acknowledgment Forms signed and dated September 6, 2017 reflects receipt of the afore-mentioned training, inclusive of the "I understand" caveat. Additionally, both contractors signed and dated a Policy Acknowledgment relative to the afore-mentioned policy, dated September 6, 2017. The "I understand" caveat is likewise present on this document. The auditor's on-site review of one Contractor training file reveals compliance with 115.232(c) as described above.

The auditor notes the standard is silent regarding refresher training. The auditor's review of one contract employee training file reveals receipt of annual In-Service PREA training. Since annual In-Service PREA training is provided to all EPTC contractors, the auditor finds EPTC to exceed compliance expectations as applied to 115.232.

## **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*)

Pursuant to the PAQ, the Director self reports 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. The Director self reports 825 residents were provided requisite information at Intake during the last 12 months. Compared against the PAQ information, this equates to 100% of the residents received through Intake during the last 12 months.

The auditor's review of the PREA Zero Tolerance Acknowledgment for Offender form reflects verbiage regarding the resident's right to be free from sexual abuse/sexual harassment and retaliation for reporting the same. The resident's name/date/and witness name/date are reflected on the same.

Additionally, the auditor's review of the CCA Facts About Sexual Assault and Sexual Abuse brochure reflects compliance with 115.233(a). Zero tolerance regarding sexual abuse/sexual harassment, reporting options, and strategies to avoid sexual abuse/sexual harassment are addressed in this document.

A CC generated video entitled PREA Multi-Language "What You Need to Know" is also included during presentation of the resident PREA education package, as well as, the El Paso Multi-Use/EPTC Facility Resident Handbook (written in English and Spanish).

According to the Intake Staff interviewee, residents are provided information about the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment during the Intake process. Specifically, incoming residents are provided an Intake packet containing PREA brochures and a Resident Handbook. Orientation is generally provided the same day, within 24 hours of Intake. During Intake, the PREA video is presented.

During the on-site audit, the auditor learned that the Intake Coordinator facilitates the Intake process (document distribution/resident training/facilitation of Orientation) and PREA screening. If the resident arrives at the facility later in the evening, the Intake Coordinator facilitates Intake and Orientation on the next calendar day, regardless of whether the same is a weekend day.

Seventeen of the 20 random resident interviewees report when they first came to EPTC, they received information about the facility's rules against sexual abuse and sexual harassment (at



Intake). Two interviewees advise they received the requisite information two days to one week later and one interviewee advises he did not receive the requisite information. The auditor's review of this resident's file reveals he received the requisite information one day subsequent to arrival. If they arrived at EPTC later in the evening, the Intake was facilitated the next day.

In addition to the above, they received information about their right not to be sexually abused or sexually harassed, how to report sexual abuse or sexual harassment, and their right not to be punished for reporting sexual abuse or sexual harassment. Responses regarding when interviewees received the latter referenced information ranged from the same day at Intake or the next day (15), can't remember (one), one week to one and one-half months (two). The auditor's review of files associated with residents described in the preceding sentence reveals both Intake and Orientation were provided either at Intake or one day later.

The auditor's review of 12 random resident files validates that Intake information and Orientation is provided no later than the day following Intake. Of note, the auditor reviewed many resident files based on the statements residents made during interviews.

In summary, all of these resources address the resident PREA educational materials required by 115.233.

Pursuant to the PAQ, the Director self reports the facility provides residents who are transferred from a different community confinement facility with refresher information as referenced above. The Director further self reports 0 residents were transferred to EPTC from a different community confinement facility within the last 12 months.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 13, section I(1) and (4) addresses 115.233(a) and (b).

According to the Intake Staff interviewee, all admissions to EPTC receive PREA education and Orientation.

Sixteen of the 20 random resident interviewees report they were transferred from either a jail or prison within the State of Texas. One interviewee relates he was committed to EPTC from the streets and one relates he was confined in a community confinement facility. The other two residents reported they arrived from Sanctions Centers.

Pursuant to the PAQ, the Director self reports resident PREA education is available in accessible formats for all residents including those who are limited English proficient, deaf, visually impaired, otherwise disabled, as well as, to residents who have limited reading skills.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 13, section I(5) addresses 115.233(c).

Resident education formats and accessibility of the same to the resident population is addressed in the narrative for 115.216 above. Discussion of topics during the Orientation phase also strengthens resident understanding of the materials presented.

Pursuant to the PAQ, the Director self reports the agency maintains documentation of resident participation in PREA education sessions.

Substantiating documentation is referenced in the narrative for 115.233(a) above. The Zero Tolerance Acknowledgment for Offender document serves this purpose.

Pursuant to the PAQ, the Director self reports the agency ensures key information about the agency's PREA policies is continuously and readily available or visible through posters, resident handbooks, or other written formats.

As previously mentioned above, the Resident Handbook serves as a PREA informational source for residents. Additionally, the auditor's observation of PREA posters, as observed during the facility tour, substantiates compliance with 115.233(e).

In view of the above, the auditor finds EPTC to be substantially compliant with 115.233.

## **Standard 115.234: Specialized training: Investigations**

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

#### **115.234 (a)**

- In addition to the general training provided to all employees pursuant to §115.231, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] X  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).] X  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).] X  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).] X  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).]  
X  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).]  
X  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*)
- X  **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports agency policy requires that investigators are trained in conducting sexual abuse investigations in confinement settings.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 7, section b(i) addresses 115.234(a).

The auditor's review of the training syllabus for the Relias Learning course entitled PREA Investigation Protocols training addresses the requirements of 115.234(b). Additionally, the certificates for the El Paso Transition Center (EPTC) Director, and the Learning and Development Trainer (LDT) relative to the afore-mentioned course, substantiate completion of requisite courses. The Investigative Staff interviewee asserts she did receive training specific to conducting sexual abuse investigations in confinement settings. The training is an on-line course presented by Relias Training. She completed the same in February, 2018.

According to the interviewee, the course details the conduct of an investigation from beginning to end, inclusive of report writing. What to look for in terms of evidence gathering, interviewing techniques, Miranda/Garrity warnings, evidence collection, and evidence locations are a few of the topics addressed in this training component.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 7, section b(i) addresses 115.234(b).

The Investigative Staff interviewee asserts the afore-mentioned curriculum included training regarding techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative or prosecution referral.

Pursuant to the PAQ, the Director self reports the agency maintains documentation showing that investigators have completed the required training. The Director self reports the agency maintains documentation showing two investigators have completed the required training. Prior to the on-site audit, the auditor was provided an additional Certificate for the Assistant Director.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 7, section b(i) addresses 115.234(c).

Documentary evidence substantiating completion of requisite training is addressed above.

The auditor finds EPTC to be substantially compliant with 115.234.

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

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

### **115.235 (a)**

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

### **115.235 (b)**

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

### **115.235 (c)**

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

### 115.235 (d)

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

### Auditor Overall Compliance Determination

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

Pursuant to the PAQ, the Director self reports the agency has a policy related to the training of medical practitioners who work regularly in its facilities. The Director further self reports one medical practitioner, who works regularly at this facility, received the training. According to the Director, this equates to 100%.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 7 and 8, section b(i) addresses 115.235(a).

According to the Medical Staff interviewee, she received specialized training regarding sexual abuse and sexual harassment. The same was presented in DVD format and covered the following topics:

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.  
 Of note, there are no mental health professionals employed at EPTC. Mental health care is accomplished in the community.

Pursuant to the PAQ, the Director self reports facility medical staff do not conduct forensic examinations. Accordingly, the auditor finds 115.235(b) to be not-applicable to EPTC.

According to the Medical Staff interviewee, no forensic examinations are conducted at EPTC.

Pursuant to the PAQ, the Director self reports documentation is maintained, showing that medical and mental health practitioners have completed the required training.

A roster from Pathlore Learning Management System reflects completion of the requisite Medical/Mental Health specialty PREA course. Additionally, the auditor's review of three Employment Education & Training Records for medical staff reveals completion of this specialized program. The auditor's review of two Pre-Service and one In-Service Training Acknowledgments reveals substantial compliance with 115.235(d). The training sessions (medical/mental health staff) reflect completion of PREA training on January 3, 2018, March 28, 2018, and May 24, 2018. Training Activity Enrollment/Attendance Rosters validate completion of requisite training.

The auditor finds EPTC to be substantially compliant with 115.235.

## 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*)

Pursuant to the PAQ, the Director self reports the agency has a policy requiring screening (upon admission to a facility or transfer to another facility) for risk of sexual abuse victimization or sexual abusiveness toward other residents.



CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 12, section H(1) addresses 115.241(a).

According to the staff who perform screening for risk of victimization and abusiveness interviewee, she does screen residents upon admission to the facility or transfer from another facility for risk of sexual abuse victimization or sexual abusiveness toward other residents. The second of two such interviewees facilitates 30-day Reassessments and accordingly could not address this provision.

In response to questions as to when they first arrived at EPTC, were they asked any questions like whether they had been in jail or prison before, whether they have ever been sexually abused, whether they identify as lesbian, gay, bisexual (LGB), and whether they think they might be in danger of sexual abuse at the facility, 14 of the 20 random resident interviewees assert they were asked all of those questions. Three interviewees arrived outside the 12 month arrival window and accordingly, they were not asked the questions. Three additional random resident interviewees assert they either were not asked these questions or they don't recall. Of note, 13 of the 20 random resident interviewees assert they were asked these questions either at Intake or during Orientation (conducted within a few days of Intake) and one interviewee asserts he was asked the questions within one week of Intake.

The auditor's review of the files related to the residents who reported they were not asked these questions contradicts their assertions in two of the three cases. In regard to the third interviewee, the file reflects he arrived on March 21, 2015 and received his initial screening on February 24, 2017.

Pursuant to the PAQ, the Director self reports Intake screening shall ordinarily take place within 72 hours of arrival at the facility. The Director self reports during the last 12 months, 825 residents entering the facility (either through Intake or transfer) whose length of stay in the facility was 72 hours or more, were screened for risk of sexual victimization or risk of sexually abusing other residents, within 72 hours of their entry into the facility. This equates to 100% of residents admitted to the facility during the last 12 months, for 72 hours or more.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 12, section H(1)(b) addresses 115.241(b).

The auditor's review of 12 random resident files, all of which were those of random resident interviewees, reveals, with the exception of the previously referenced resident with an arrival date in 2015, all of the initial PREA screenings were complete, thorough, and timely (completed on the date of arrival or the next day as described in the narrative for 115.33).

Of note, the staff who perform screening for risk of victimization and abusiveness interviewee (Intake) advises she reviews incoming resident information received from TDCJ and prepares a preliminary PREA screening to alert staff making bed assignments of potential victimization or abusiveness concerns. She facilitates this process when she is aware of late arrivals. On the next

day (regardless of whether the same is a non-regular business day), she completes the initial screening with the resident.

According to the staff who perform screening for risk of victimization and abusiveness interviewee, she screens incoming residents within 24 hours of Intake. Generally, with the exception of the late arrival situation referenced above, screening is conducted on the same day of arrival at EPTC.

Pursuant to the PAQ, the Director self asserts risk assessment is conducted using an objective screening instrument.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 12, section H(1)(a) addresses 115.241(c).

The auditor's review of the CC 14-2B CC, Sexual Abuse Screening Tool, reveals the same is an objective screening tool.

The auditor's review of the Sexual Abuse Screening Tool reveals substantial compliance with 115.241(d). Specifically, the document addresses the following issues:

- 1) Whether the resident has a mental, physical, or developmental disability;
- 2) The age of the resident;
- 3) The physical build of the resident;
- 4) Whether the resident has previously been incarcerated;
- 5) Whether the resident's criminal history is exclusively nonviolent;
- 6) Whether the resident has prior convictions for sex offenses against an adult or child;
- 7) Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming;
- 8) Whether the resident has previously experienced sexual victimization; and
- 9) The resident's own perception of vulnerability.

To expound upon the narrative reflected in 115.241(b), the staff who perform screening for risk of victimization and abusiveness interviewee asserts that rarely, a resident arrives at the facility after she has departed for the day. As is the case with all pending arrivals, she has received an admission packet with information from TDCJ and she has reviewed relevant PREA information.

Additionally, she has pre-entered victim and abuser information into the electronic system and “alerts” register based on the information entered. While she validates the information with the resident the next day, entering source information preemptively serves to ensure potential victims and aggressors are not housed in close proximity to one another. If security precautions might be necessary, assignment staff can draw those conclusions based on the data entered. Potential victims and potential abusers may be housed under cameras and they will be geographically separated within the unit. If need be, potential victims and potential abusers may be separated by housing unit, dependent upon the circumstances.

Of note, the above represents the same process utilized during any such screening.

Victims of sexual abuse in the past, whether the resident has been approached by other residents in the past with sexual innuendos, resident's perception of safety at the facility, disabilities, current or prior sexual abuse convictions, current or past violent offenses, whether the resident is a victim or perpetrator, and whether the resident has been sanctioned for violence while incarcerated, are a few of the screening tool considerations.

The interviewee asserts after Intake security processing, the resident is escorted to her office (behind closed doors) where the resident is issued an Intake PREA packet and the screening tool is administered.

The auditor's review of the Sexual Abuse Screening Tool reveals substantial compliance with 115.241(e). Specifically, the same addresses prior acts of sexual violence, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse.

Pursuant to the PAQ, the Director self reports policy requires the facility reassess each resident's risk of victimization or abusiveness within a set time period, not to exceed 30 days after the resident's arrival at the facility, based upon any additional, relevant information received by the facility since the intake screening. The Director self reports during the last 12 months, 825 residents entering the facility (either through Intake or transfer) were reassessed for their risk of sexual victimization or of being sexually abusive, within 30 days after their arrival at the facility based upon any additional, relevant information received since Intake. This equates to 100% of admissions during the referenced time frame.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 12, section H(2)(a) addresses 115.241(f).

According to a Case Manager who facilitates screening for risk of victimization and abusiveness (30-day Reassessment) interviewee, reassessments are facilitated within 30 days of arrival at the facility. He asserts the Assessment Due date appears at the 25 day date (from date of Initial Screening) on the SECUR Management System. He then proceeds with the re-assessment process, conducting the same with the resident in a private area behind closed doors.

Of the 20 random resident interviewees, eight assert a reassessment was completed. Time frames in which the reassessments were completed range from 30 days following Initial Screening (four interviewees), to two to three months following Intake, to two-five times since Initial Screening. Six interviewees assert they were not reassessed. Three interviewees arrived outside the 12 month arrival window and accordingly, they were not questioned regarding reassessments.

The auditor's review of two reassessments in follow-up to initial assessments (PAQ information) reveals timely completion of the same in accordance with the provision.

The auditor's on-site review of 12 random resident files, all of which were those of random resident interviewees, reveals eight of the 30-day Reassessments were complete, thorough, and timely (completed within 30 days of the date of arrival or the next day as described in the narrative above). Of note, the previously referenced resident who arrived in 2015 but received Initial PREA Screening in 2017 (February 24, 2017) was reassessed on March 13, 2017.

Pursuant to the PAQ, the Director self reports the policy requires 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 13, section H(2)(b) addresses 115.241(g).

According to the previously mentioned Case Manager who facilitates screening for risk of victimization and abusiveness (30-day Reassessment) interviewee, reassessments are facilitated, as needed, 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.

The auditor's review of one reassessment facilitated in accordance with 115.241(g) reveals substantial compliance with the provision. The basis for the reassessment is clearly identified in the body of the document.

Pursuant to the PAQ, the Director self reports policy prohibits disciplining residents for refusing to answer (or for not disclosing complete information related to) 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 lesbian, gay, bisexual, transgender, intersex, or gender nonconforming;
- Whether or not the resident has previously experienced sexual victimization; and
- The resident's own perception of vulnerability.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 13, section H(3)(a-d) addresses 115.241(h).

Both staff who facilitate screening for risk of victimization and abusiveness interviewees relate residents are not disciplined in any way for refusing to respond to (or for not disclosing complete information related to) the following:

- Whether the resident has a mental, physical, or developmental disability;
- Whether the resident is or is perceived to be LGBTI or gender non-conforming;
- Whether the resident has previously experienced sexual victimization;
- The resident's own perception of vulnerability.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 13, section H(4) addresses 115.241(i).

According to the EPTC PCM, the agency has outlined who should have access to a resident's risk assessment within the facility in order to protect sensitive information from exploitation. Specifically, she asserts Case Managers, the Case Management Supervisor, Assistant Director, Director, and Program Manager are the primary staff given authorization. Access is on a "Need to Know" basis.

The staff who facilitate screening for risk of victimization and abusiveness interviewees relate such access is limited to the Director, Assistant Director, and Case Management staff.

In view of the above, the auditor finds EPTC to be substantially compliant with 115.241.

## Standard 115.242: Use of screening information

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

### 115.242 (a)

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

### 115.242 (b)

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

### 115.242 (c)

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

### 115.242 (d)

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

### 115.242 (e)

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

### 115.242 (f)

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

### Auditor Overall Compliance Determination

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

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

Pursuant to the PAQ, the Director self reports the facility uses information from the risk screening 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 12, section H(1) addresses 115.242(a).

According to the EPTC PCM, the information gleaned from risk screening is used to geographically separate, using security practices, potential victims and potential abusers. Potential victims and potential abusers may be placed under cameras in separate units or separate areas within a unit.

According to one staff who perform screening for risk of victimization and abusiveness interviewee, she screens incoming residents within 24 hours of Intake. Generally, incoming residents are screened upon the day of arrival, with the exception of an after-hours arrival.

Rarely, a resident arrives subsequent to the interviewee's departure for the day. However, if the interviewee is aware the incoming resident will arrive during non-regular business hours, she ensures she has entered victim and abuser information she has gleaned from the admission packet she received from TDCJ, into the system to aid assignment staff in making a bed assignment. Subsequently, the interviewee validates the information on the next calendar day with the resident in attendance.

Pursuant to the PAQ, the Director self reports the facility makes individualized determinations about how to ensure the safety of each resident.

Relevant policy provisions are addressed in the narrative for 115.242(a) above.

Pursuant to the PAQ, the Director self reports the facility makes housing and program assignments for transgender or intersex residents in the facility on a case-by-case basis.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 14, section J(1)(a) addresses 115.242(c).

According to the EPTC PCM, the screening assessment tool is used to assign housing and programming assignments for all residents. Assignments are based on management considerations and in consideration of the resident's safety. Transgender and intersex residents are not routinely assigned to a specific housing unit, unless circumstances dictate specific housing. Additionally,



transgender/intersex resident's own views with respect to his own safety, are given serious consideration in placement and programming assignments.

The transgender resident interviewee asserts he has been questioned regarding his safety. Additionally, he has not been placed in a housing unit only for transgender or intersex residents. He does not believe he has been strip-searched for the sole purpose of determining genital status.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 14, section J(1)(a) addresses 115.242(d).

Both staff who perform screening for risk of victimization and abusiveness interviewees relate transgender/intersex resident's own views regarding his own safety are given serious consideration in placement and programming assignments.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 15, section K(7) addresses 115.242(e).

According to the EPTC PCM, transgender and intersex residents are afforded the opportunity to shower separately from other residents. Staff are posted outside the shower while in use for this purpose. Generally, showers are facilitated during the evening.

Both staff who perform screening for risk of victimization and abusiveness interviewees relate transgender/intersex residents are afforded the opportunity to shower separately from other residents, should they so desire.

The transgender resident interviewee asserts he is allowed to shower alone. Specifically, he showers separately at night.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 14, section J(1)(b) addresses 115.242(f).

According to the EPTC PCM, the agency is not subject to a consent decree, legal settlement, or legal judgment requiring that it establish a dedicated facility, unit, or wing for LGBTI residents. The EPTC PCM reviews housing assignments at least monthly to assess safe housing and housing in accordance with PREA standards. Supervisors also monitor housing assignments, at least weekly, to guard against housing arrangements in violation of PREA standards.

According to the one gay resident interviewee, he is not housed, nor has he been housed, in a housing area only for LGBTI residents.

In view of the above, the auditor finds EPTC to be substantially compliant with 115.242.



## 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*)

Pursuant to the PAQ, the Director self reports the agency has established procedures allowing for multiple internal ways for residents to report privately to agency officials about:

Sexual abuse or sexual harassment;  
Retaliation by other residents or staff for reporting sexual abuse and sexual harassment; and  
Staff neglect or violation of responsibilities that may have contributed to such incidents.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 15, section L(1)(a) addresses 115.251(a).

All 13 random staff interviewees were able to identify at least one option for resident reporting of sexual abuse and sexual harassment. Eleven interviewees identified two or more. Responses included verbal reports, written reports, PREA Hotline, and third-party reports.

All 20 random resident interviewees were able to identify at least one option for resident reporting of sexual abuse and sexual harassment. Eighteen interviewees identified two or more options for reporting. Responses included verbal report to a Monitor or other staff, Hotline reporting, advise family, and third-party reports.

During the facility tour, the auditor noted wide distribution of reporting options throughout the housing units, program, and operational areas. PREA posters clearly reflect contact numbers for the TDCJ PREA Ombudsman and CASFV. PREA Hotline memorandums are posted in the vicinity of resident telephones located in the resident housing areas. Random interviews with seven residents throughout the facility tour reveals an understanding of resident reporting options.

Pursuant to the PAQ, the Director self reports 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 15, section L(1)(a) and page 17, section 3 address 115.251(b).

The auditor's review of brochures, posters, and the Resident Handbook reveals relevant telephone numbers commensurate with this standard.

According to the EPTC PCM, residents can report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency pursuant to a Hotline. These procedures enable receipt and immediate transmission of resident reports of sexual abuse and sexual harassment to agency officials that allow the resident to remain anonymous upon request.

The EPTC PCM relates the TDCJ Hotline is not as reliable in terms of Director notification based on hours of operation. CASFV protocol and procedures are addressed in the MOU between EPTC and CASFV. CASFV is toll-free and the reporting resident is allowed to remain anonymous.

Fourteen of the 20 random resident interviewees assert they can make a report of sexual abuse or sexual harassment without having to give their name. Four interviewees did not know whether they can make a report of sexual abuse or sexual harassment without having to give their name and two said they could not report under such circumstances.

Pursuant to the PAQ, the Director self reports the agency has a policy mandating staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties. The Director further self reports staff are required to document verbal reports. The time frame in which staff are required to document such verbal reports is "immediately".

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 16, section 2 addresses 115.251(c).

Twelve of the 13 random staff interviewees assert when a resident alleges sexual abuse, he can do so verbally, in writing, anonymously, and from third parties. One interviewee asserts third parties cannot report sexual abuse on behalf of a resident and anonymous reports cannot be made. All interviewees assert they immediately document verbal reports following receipt of the same.

Nineteen of the 20 random resident interviewees assert they can make reports of sexual abuse or sexual harassment both verbally and in writing and one asserts a resident can only report verbally. Thirteen interviewees assert someone else can make the report for the resident without giving their name while three assert the same cannot be done. Four interviewees assert they don't know if the same can be accomplished.

Pursuant to the PAQ, the Director self reports the agency has established procedures for staff to privately report sexual abuse and sexual harassment of residents. Of note, the TDCJ PREA Ombudsman's Office telephone number is listed in the following policy. The auditor's review of the CC website reveals private staff reporting information. The same can generally be accomplished through reporting to the Ethics Hotline. Staff are alerted to reporting procedures pursuant to Pre-Service and In-Service training.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 17, section 2(d) addresses 115.251(d).

During the facility tour, the auditor did observe posting of the Ethics Hotline poster in staff gathering areas.

All 13 random staff interviewees identified at least one option to privately report sexual abuse and sexual harassment of residents. Reporting methods cited included verbal or face-to-face report to supervisor, report to the Director or other executive staff, contact the Resident PREA Hotline, contact the Ethics Hotline, submit a written report, anonymous report, and submit an e-mail.

The auditor finds EPTC to be substantially compliant with 115.251.

## Standard 115.252: Exhaustion of administrative remedies

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

#### 115.252 (a)

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

#### 115.252 (b)

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

#### 115.252 (c)

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

#### 115.252 (d)

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

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

#### 115.252 (e)

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

#### 115.252 (f)

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

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

### 115.252 (g)

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

### Auditor Overall Compliance Determination

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

According to the EPTC PCM, there is no separate EPTC policy/process for sexual abuse/harassment grievances. If a resident submits a sexual abuse/sexual harassment complaint in accordance with the regular Grievance program, the same is reported immediately to administration by the Grievance Officer and an investigation is immediately and expeditiously conducted.

Residents place routine grievances in a locked box in a common area. The Intake Coordinator/Grievance Officer (one person, two responsibilities) checks the box daily and is the only one with access to the grievance(s). Sometimes residents will skip the box and take grievance(s) directly to the Intake Coordinator/Grievance Officer.

In view of the above, the auditor finds EPTC to be substantially compliant with 115.252.

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

### Auditor Overall Compliance Determination

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

Pursuant to the PAQ, the Director self reports the facility provides residents with access to outside victim advocates for emotional support services related to sexual abuse by:

Giving residents mailing addresses and telephone numbers (including toll-free hotline numbers where available) for local, state, or national victim advocacy or rape crisis organizations; Enabling reasonable communication between residents and these organizations in as confidential manner as possible.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 10, section F(2) addresses 115.253(a).

The auditor's review of the PREA Zero Tolerance Acknowledgment for Offenders (signed and dated by the resident and a staff member) clearly reflects the telephone number for CASFV. The CASFV brochure reflects the resident's right to counseling and treatment at no charge, as well as, the CASFV address and telephone number.

In response to questions regarding:

Whether there are services available outside of EPTC for dealing with sexual abuse;  
What kind of services are available;



Whether EPTC provides mailing address(es) and telephone number(s) for such outside services, inclusive of whether the numbers are free to call; and  
When affected residents are able to talk with people from these services;  
random resident responses were widely varied with seemingly little knowledge of the subject-matter. For example, 16 of 20 interviewees assert they know there are services available outside the facility for dealing with sexual abuse however, only eight interviewees were able to identify one service. Counseling, medical, and crisis services were the most common citations.

Ten interviewees also cite the fact the facility provides mailing addresses and telephone numbers to residents either through resident handbooks, pamphlets, or notices posted on bulletin boards. Fifteen interviewees assert contact with people from these service can be accomplished anytime.

The resident who reported a sexual abuse interviewee asserts the facility does not provide mailing addresses and telephone numbers for outside services. He followed, stating he did not know if the information is in the Resident Handbook. He further stated he did not know under what circumstances he would be able to talk with people who provide such services. Finally, he did not know when he could communicate with those people in a confidential way.

Given the above, the auditor finds residents have, at their fingertips, sufficient information to be fully informed regarding the parameters of 115.253(a).

Pursuant to the PAQ, the Director self reports the facility informs residents, prior to giving them access to outside support services, of the extent to which such communications will be monitored. The Director further self reports the facility informs residents, prior to giving them access to outside support services, of the mandatory reporting rule governing privacy, confidentiality, and/or privilege that applies to disclosure of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant federal, state, or local law.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 10, section F(3) addresses 115.253(b).

While policy addresses this provision, the auditor has found no method of advising residents as to monitoring of communications with outside support services and mandatory reporting rules. Accordingly, the auditor finds EPTC to be non-compliant with 115.253(b).

In view of the above, corrective action is required to address this provision. Corrective action must be completed within 180 days of the date of this report or on or before April 6, 2019. The auditor can close the corrective action period prior to this date if he is convinced the practice is institutionalized.

To attain compliance with 115.253(b), the EPTC PCM will collaborate with Corporate staff, developing posters to be hung throughout the facility, addressing the parameters of confidentiality



and mandatory reporting related to communication with assistance services. While every specific scenario cannot be brainstormed and captured on one poster, general information can be provided to alert residents regarding service provider obligations to report. Additionally, the EPTC PCM will capture the information provided on the poster, transferring the same to the Resident Handbook. With this strategy, residents will readily have access to the requisite information immediately upon Intake. The EPTC PCM will forward copies of the above to the auditor for review and inclusion in the audit file.

In addition to the above, this information will be included in the Orientation presentation. Accordingly, the Orientation lesson plan must be modified to address the same. The EPTC PCM will forward a copy of the amended plan to the auditor for inclusion in the record.

Finally, staff stakeholders must be notified regarding this information. Accordingly, a memorandum can be developed, articulating the parameters as referenced above, and distributed to the Director, EPTC PCM, Quality Manager, PREA Investigator, all Case Management staff, and any other stakeholders. A copy of the memorandum, inclusive all stakeholders' signatures and date(s) of receipt, will be forwarded to the auditor for inclusion in the record. In the alternative, the EPTC PCM can develop a training syllabus and forward the same to the auditor, inclusive of training documents reflecting staff completion of the training.

#### **November 29, 2019 Update:**

**The auditor has been provided with five photographs of posters that have been posted throughout the facility, alerting residents to the fact some of their conversations with outside providers regarding issues related to sexual abuse, may be listened to or shared with community stakeholders. The verbiage reflected in these posters primarily references Mandatory Reporting subject-matter.**

#### **December 13, 2018 Update:**

**Pursuant to memorandum dated December 7, 2018, from the EPTC Director to the EPTC Intake Coordinator, she is directed to appropriately inform, at Orientation, incoming residents of the Mandatory Reporting obligations of staff providing telephonic or personal services to EPTC victims of sexual abuse. The intake Coordinator signed and dated this memorandum on December 7, 2018.**

**In addition to the above, the CC Zero Tolerance Acknowledgements for Offenders document has been revised to include the information regarding limits of confidentiality and Mandatory Reporting requirements for community service providers of sexual abuse services. This document is signed at Intake (See the narrative for 115.233).**

**In view of the above, the auditor finds EPTC is now substantially compliant with 115.253. Accordingly, this finding is closed.**

In response to whether they know if what they say to people from these services remains private or whether conversations with them could be told to or listened to by someone else, 13 of the 20 random resident interviewees assert what one says to people from these services remains private. Four interviewees advise conversations may be told to or listened to by someone else, with examples of when this may occur. Six interviewees did not have an answer in response to these questions. These questions will be addressed pursuant to the corrective action noted above.

Pursuant to the PAQ, the Director self reports the facility maintains memoranda of understanding (MOUs) or other agreements with community service providers that are able to provide residents with emotional support services related to sexual abuse. The Director further self reports the facility maintains copies of the agreements.

The auditor's review of the MOU with CASFV reveals the same is commensurate with 115.253(c). The same is also addressed in the narrative for 115.221 above. While the MOU has not yet been signed, the auditor's review of e-mail communication reveals attempts to complete the MOU process with CASFV.

In view of the above, the auditor finds EPTC substantially compliant with 115.253.

## **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*)

Pursuant to the PAQ, the Director self reports the facility provides a method to receive third-party reports of resident sexual abuse or sexual harassment.

According to the CCA Preventing Sexual Misconduct brochure, third-party reporters can report sexual abuse or sexual harassment by calling the two toll-free telephone numbers listed in the brochure. The PREA Ombudsman's Office brochure reflects the address and telephone number for the Ombudsman's Office. On page 7 of the Resident Handbook, third-party reporting procedures are articulated.

The auditor's review of the CC website reveals requisite information regarding third-party reporting. The auditor recommends contact information for third-party reports be posted in the Lobby area of the facility so third-party visitors to the facility have access to reporting information.

In view of the above, the auditor finds EPTC to be substantially compliant with 115.254.

## 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?  
X  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? X  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? X  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? X  Yes  No

### Auditor Overall Compliance Determination

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

Pursuant to the PAQ, the Director self reports the agency 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;  
Any retaliation against residents or staff who reported such an incident; or  
Any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 16, section 2(a)(i-iii) addresses 115.261(a).

All 13 random staff interviewees assert the agency requires all staff to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility; retaliation against residents or staff who reported such an incident; and any staff neglect

or violation of responsibilities that may have contributed to an incident or retaliation. All of the 13 interviewees assert such reports must be made immediately to their supervisor, the Director, or both.

Pursuant to the PAQ, the Director self reports apart from reporting to designated supervisors or officials and designated state or local service 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 16 and 17, section 2(c) addresses 115.261(b).

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 17, section 2(e) addresses 115.261(c).

The auditor's review of a Sexual Abuse Incident Check Sheet reveals significant detail in terms of notifications regarding an alleged sexual abuse incident. The document substantiates compliance with the provision.

According to the Medical Staff interviewee, at the initiation of services to residents, she discloses the limitations of confidentiality and her duty to report. She relates this practice is policy and training/education driven.

The interviewee asserts she is required to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment to a designated supervisor or official immediately upon learning of it. She would report to the Compliance Manager.

The interviewee asserts she became aware of an event in June, 2018. The event actually occurred two days earlier. The resident did not report the incident to her.

The auditor's review of seven sexual abuse investigations reveals facility Medical staff were not involved in any of the incidents. In one case, the victim refused medical and Victim Advocate services.

Of note, medical coverage is limited at EPTC, both by function and coverage.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 17, section 2(f) addresses 115.261(d).

According to the Director and EPTC PCM, residents under the age of 18 are not accepted at EPTC. In the event a sexual abuse or sexual harassment allegation is received from a vulnerable adult, the matter is thoroughly investigated and reported to the relevant social services agency [Adult Protective Services (APS)].

The auditor has not been provided any information relative to allegation(s) received from vulnerable adults.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 16, section 2 addresses 115.261(e).

According to the Director, all allegations of sexual abuse and sexual harassment (including those from third-parties and anonymous sources) are reported directly to designated facility investigators. The Investigator generally reports to the facility to commence the investigation when called.

In view of the above, the auditor finds EPTC to be substantially compliant with 115.261.

## 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*)

Pursuant to the PAQ, the Director self reports when the facility learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident (e.g., it takes some action to assess and implement appropriate protective measures without unreasonable delay). The Director further self reports in the past 12 months, there were 0 times the facility determined a resident was subject to substantial risk of imminent sexual abuse.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 1, Policy section addresses 115.262(a).

The Agency Head interviewee advises immediate isolation of the potential victim is the initial response to a report of substantial risk of imminent sexual abuse. It may be feasible to move the potential victim to another housing unit within the facility, dependent upon the circumstances. The potential perpetrator may also be placed under direct staff supervision status. The contractual requirements of the Governmental partner will dictate the ability to transfer both the potential victim

and potential perpetrator. Minimally, we would work with on-site contract monitors to make the best decision under the circumstances.

The Director asserts when it is learned a resident is subject to a substantial risk of imminent sexual abuse, staff maintain the potential victim, he is removed from the danger zone, and he interviews him. If the resident victim feels safe at EPTC, he could be moved to another dormitory. If not, the Director would attempt to transfer the potential victim to the El Paso Multi-Use Facility [(MUF) located adjacent to EPTC].

Twelve of the 13 random staff interviewees assert they would separate the potential victim and perpetrator by removing the victim from the area (danger zone) immediately. Many interviewees also assert they would alert their supervisor. One interviewee reports he/she would contact his/her supervisor immediately.

In view of the above, the auditor finds EPTC to be substantially compliant with 115.262.

### **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*)

Pursuant to the PAQ, the Director self reports the agency has a policy requiring that, upon receiving an allegation a resident was sexually abused while confined at another facility, the head of the receiving facility must notify the head of the facility or appropriate office of the agency or facility where sexual abuse is alleged to have occurred. The Director further self reports in the past 12 months, the facility received 1 allegation a resident was abused while confined at another facility.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 20, section 5(a) addresses 115.263(a).

The auditor's review of copies of e-mails regarding the afore-mentioned allegation reveals the same was reported to the TDCJ Monitor and other TDCJ officials in timely manner. The Senior Warden at the facility at where the alleged incident occurred, was also notified.

Pursuant to the PAQ, the Director self reports agency policy requires the facility head to provide such notification as soon as possible, but no later than 72 hours after receiving the allegation.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 20, section 5(a) addresses 115.263(b).

Pursuant to the PAQ, the Director self reports the facility documents it has provided such notification within 72 hours of receiving the allegation.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 20 and 21, section 5(b)(i) and (c) address 115.263(c).

Pursuant to the PAQ, the Director self reports facility policy requires allegations received from other facilities/agencies are investigated in accordance with PREA standards. The Director further self reports in the past 12 months, there were 0 allegations of sexual abuse received by the facility from other facilities.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 21, section 5(d) addresses 115.263(d).

The Agency Head interviewee advises if another agency or facility within another agency refers allegations of sexual abuse or sexual harassment that occurred within a CC facility, the Director is generally the administrator who receives the call. Subsequent to receipt of such a call, the Director would advise the facility Investigator to open an investigation. Dependent upon the circumstances, the Investigator would initiate an administrative investigation or contact the El Paso Sheriff's Department to initiate a criminal investigation.

According to the Director, the matter is treated like any PREA incident with a full investigation initiated, whenever an allegation is received from another facility or agency that an incident of sexual abuse or sexual harassment previously occurred at EPTC. The Investigator would interview the complainant wherever he is now located. There are no examples of another facility or agency reporting such allegations during the Director's tenure at EPTC.

In view of the above, the auditor finds EPTC to be substantially compliant with 115.263.

## 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*)

Pursuant to the PAQ, the Director self reports the agency has a first responder policy for allegations of sexual abuse. The Director further self reports the agency policy requires, 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:

- 1) Separate the alleged victim and abuser;
- 2) Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence;
- 3) If the abuse occurred within a time period that still allows for the collection of physical evidence, request 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; and
- 4) If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure the alleged abuser does not take any actions that could destroy physical evidence such as those described in paragraph 3 above.

The Director self reports no alleged incidents of sexual abuse occurred at EPTC during the last 12 months. However, the auditor did review seven investigations on-site that were identified as sexual assault investigations. The Director self reports none of the First Responder duties, as articulated in 115.264(a) were facilitated with respect to these matters and this is consistent with the auditor's findings.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 17 and 18, section M(1) (a-c) and M(2)(a) addresses 115.264(a).

The auditor's review of a CC First Responder card reveals substantial compliance with 115.264(a).

All six random security first responder interviewees incorrectly identified the steps necessary for first responders. Specifically, these First Responders incorrectly identified some of the steps required of First Responders. Of note, the inaccuracies identified center on requesting that the alleged victim not take any actions that could destroy physical evidence and securing the crime scene (1). Affected interviewees assert the employee must ensure, or not allow both the victim and perpetrator, to destroy physical evidence.

Of the remaining seven random staff interviewees, four of the seven also provided incorrect responses relative to First Responder duties. The incorrect responses are identical to those referenced above. The non-security staff who may act as a first responder interviewee likewise asserts the employee must ensure, or not allow, both the victim and perpetrator to destroy physical evidence.

All interviewees were in possession of the previously mentioned CC card reflecting First Responder steps to be taken in the event of a sexual abuse allegation.

The resident who reported a sexual abuse interviewee asserts he did not report the incident to the Director until four hours following the same. PREA procedures were immediately invoked upon notification. The interviewee asserts the staff who subsequently responded to the scene, responded quickly. The alleged perpetrator was immediately moved to another unit and the victim remained in place.

While the auditor does not find sufficient basis to find EPTC non-compliant with 115.264 based on the afore-mentioned issue and evidence, there is cause to re-train staff regarding the same. As all staff receive the same First Responder training, refresher training appears to be an appropriate remedy.

In view of the above, the EPTC PCM will ensure all staff receive training regarding the four steps to be employed by First Responders, emphasis added relative to “requesting” the victim to refrain from destroying physical evidence. Of note, First Responder refresher training must be completed on or before January 5, 2019.

The EPTC PCM will provide a roster of all staff to the auditor and he will randomly select staff names. The EPTC PCM will provide training certifications substantiating provision of the relevant training for each selectee. Additionally, the EPTC PCM will provide a copy of the training syllabus to the auditor.

#### **November 29, 2018 Update:**

**The EPTC PCM has forwarded to the auditor a Training Activity Enrollment/Attendance Roster and Supervisory Meeting Minutes reflecting the lesson plan and PREA issues addressed pursuant to the findings articulated in this report. The requirements reflected above are clearly represented in the lesson plan. Printed staff names and signatures are also reflected on the same. The document appears to encompass all EPTC staff.**

**In view of the above, the auditor finds recommended action to be satisfactory.**

Pursuant to the PAQ, the Director self reports agency policy requires if the first responder is not a security staff member, the responder shall be required to:

- 1) Request that the alleged victim not take any actions that could destroy physical evidence; and
- 2) Notify security staff.

The Director further self reports that of the allegations of sexual abuse within the past 12 months, there were 0 times a First Responder was a non-security staff member.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 18, section M(1)(e) addresses 115.264(b).

Of note, all staff receive the same First Responder training as all staff receive the same PREA training, both Pre-Service and In-Service. Furthermore, all staff receive the afore-mentioned CC First Responder card.

In view of the above, the auditor finds EPTC to be substantially compliant with 115.264.

## 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*)

Pursuant to the PAQ, the Director self reports the facility 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 10-12, section G(1-3) and pages 17-26, sections M-O address 115.265(a). Specific duties and responsibilities are articulated for various titles and departments as a response to an incident of resident sexual abuse. The auditor's review of this plan reveals a comprehensive and substantive plan to enable proper staff response to an incident of sexual abuse.

According to the Director, the facility does have a comprehensive plan (cradle to grave) covering duties for all stake holders from staff first responders, medical (Note: mental health practitioners are available only in the community and medical privileges are limited at EPTC), investigators, Retaliation Monitoring, facility leadership, and reporting to Corporate leadership in response to an incident of sexual abuse. Staff are trained during Pre-Service and annually during In-Service training regarding the mechanics of this plan. A checklist is used to track all activities articulated in the plan.

In view of the above, the auditor finds EPTC to be substantially compliant with 115.265.

## 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*)

Pursuant to the PAQ, the Director self reports the facility is not involved in any collective bargaining process, either currently or since the last PREA audit.

In view of the above, the auditor finds EPTC to be substantially compliant with 115.266.

## 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*)

Pursuant to the PAQ, the Director self reports the agency has a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff. According to the Director, the Learning Development Manager (PREA Investigator) is the designated Retaliation Monitor.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 11, section 3(a)(iv) addresses 115.267(a).

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 12 and 13, sections 3(a) (vii through ix) and 3(b)(i) addresses 115.267(b).

According to the Agency Head interviewee, staff and inmates who report sexual abuse/sexual harassment allegations are protected from retaliation pursuant to frequent retaliation monitoring check-ins (inmates/staff), in addition to a 30/60/90 day formal review schedule. Staff charged with retaliation monitoring responsibilities follow disciplinary action(s), housing unit changes, removal

of perpetrator(s) from area of victim housing, transfer of alleged abuser(s), and change in programming. In regard to alleged staff perpetrators, monitoring and follow-up regarding staff conduct is a primary consideration to the inmate safety equation.

The Director asserts the following measures may be employed to address allegations of sexual abuse or sexual harassment in an effort to protect residents and staff from retaliation: remove alleged abuser from the area; follow up with victim pursuant to 30/60/90 day monitoring intervals with status checks on a weekly basis; move a resident to another unit/facility; contact Parole for early release/placement in another location; recommend services; move alleged staff perpetrators to another shift or facility; place on Administrative Leave pending completion of the investigation; and terminate employment if found to have committed the act. Additionally, implementation of increased security rounds or checks are effective strategies.

The Staff Member Charged with Retaliation Monitoring relates that within days of the alleged incident, she initiates contact with the victim. We then institute retaliation monitoring. Strategies to ensure retaliation victim safety and security include transfer of the alleged perpetrator or victim, offer services, effect housing change(s), enhance supervision with 15 minute rounds, offer additional one-on-one supervision, and increase check-ups.

The auditor's review of seven EPTC sexual abuse investigations and PREA Retaliation Monitoring Reports (occurred in the last 12 months) reveals investigations were completed in a timely manner with implementation of Retaliation Monitoring following in close proximity. The 30/60/90 day contacts are implemented and completed unless mitigating circumstances (e.g. resident absconded, resident was placed in a local hospital, or arrested) prevail. This occurred in all but two cases. The allegation in the seventh matter was determined to be Unfounded.

The resident who reported a sexual abuse asserts he feels protected enough against possible revenge from staff or other residents because you reported what happened to you.

Pursuant to the PAQ, the Director self reports the facility monitors the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff. The Director reports retaliation monitoring is continued for at least 90 days or more, if necessary. The agency does act promptly to remedy such retaliation. The facility continues such monitoring beyond 90 days if the initial monitoring indicates a continuing need. The Director self reports retaliation has not occurred within the last 12 months.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 11, sections 3(a)(iv and v) addresses 115.267(c). Documented monitoring occurs at 30/60/90 day intervals.

The staff member charged with Retaliation Monitoring interviewee asserts she assesses increases in resident receipt of misconduct reports, increased complaints, decreased hygiene, isolation, and

multiple housing change requests in terms of retaliation monitoring. The conduct and treatment of residents and staff who report the sexual abuse of a resident or were reported to have suffered sexual abuse are monitored on a 30/60/90 day basis with an additional 120-day check-in, if needed. The Director would extend monitoring for good cause. Actually, monitoring can be extended beyond 120 days based on a collaborative decision with the Director and Assistant Director.

Of note, the auditor has learned retaliation monitoring of staff is conducted by the Assistant Director.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 11, section 3(a)(iv) addresses 115.267(d). The auditor recommends that a prescribed status check time line and documentation of the same be added to policy.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 11, section 3(a)(iv) addresses 115.267(d).

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 11, section 3(a)(vi) addresses 115.267(e).

When an inmate who cooperates with an investigation expresses fear of retaliation, the Agency Head interviewee asserts he receives the same benefits and treatment as articulated in the narrative for 115.267(b) above.

The auditor finds EPTC to be compliant with 115.267.

## 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).] X  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).] X  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?  
X  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? X  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?  
X  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).] X  Yes  No  NA

#### Auditor Overall Compliance Determination

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

Pursuant to the PAQ, the Director self reports the facility has a policy related to criminal and administrative agency investigations.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 1, section entitled Policy and 16, section 2 addresses 115.271(a).

According to the investigative staff interviewee, sexual abuse and sexual harassment allegations are generally initiated immediately. If she is advised of an allegation, she reports to the facility immediately. The interviewee asserts she is on call.

Third-party and anonymous reports of sexual abuse or sexual harassment are handled the same as any allegation.

The previously referenced investigation reports (see narrative for 115.267) reveal a joint investigative endeavor between CC and the El Paso Sheriff's Department. The auditor's review of the same reveals a thorough investigation addressing all tenets of 115.271.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 7, sections M(1 and 2), page 19, section 3(f), and page 25, section 3(b) address 115.271(b).

The investigative staff interviewee asserts she received training (Relias Training completed in February, 2018) specific to conducting sexual abuse investigations in confinement settings. She asserts the training detailed the conduct of an investigation from beginning to end, inclusive of report writing. What to look for in terms of evidence gathering, interviewing techniques, Miranda/Garrity warnings, evidence collection, and evidence locations are a few of the topics addressed in this training component.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 17 and 18, 19, section 3(g), and 24, sections a-c address 115.271(c).

According to the investigative staff interviewee, the following investigative steps and associated time estimates, constitute the investigative process: 1. Separate the victim and perpetrator (3-4 minutes); 2. Interview the victim while awaiting transportation for forensic examination, if appropriate (1-2 hours); 3. Interview witnesses (15 minutes to 2 hours); 4. Retrieve staff reports (1 hour); 5. Review documentation and other evidence prior to interviewing the perpetrator (1 hour); 6. Interview perpetrator (15 minutes to 1 hour); and 7. Gather video, interview Monitors, review files to establish whether the perpetrator has a history of sexual assault or an associated disciplinary history (1 hour).

In regard to direct and circumstantial evidence, the investigative staff interviewee asserts she confers with the El Paso Sheriff's Department regarding bagging and tagging physical evidence. Generally, they prefer to handle the same. Circumstantial evidence collection is addressed in the preceding paragraph.

The auditor's review of the 1-15-CC Form reveals retention time lines regarding investigative materials. Additionally, the auditor's review of the afore-mentioned sexual abuse investigations reveals substantial compliance with 115.271(c).

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 23, section O, and 24, section O(2)(d) address 115.271(d).

According to the investigative staff interviewee, she consults with the El Paso Sheriff's Department regarding potential criminal cases. El Paso Sheriff's Department investigators conduct compelled interviews.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 24, section O(1)(d) addresses 115.271(e).

The investigative staff interviewee asserts all alleged victims, suspects, or witnesses are credible until proven otherwise. She further relates she would not, under any circumstances, require a resident who alleges sexual abuse to submit to a polygraph examination or truth-telling device as a condition for proceeding with an investigation.

The resident who reported a sexual abuse interviewee asserts he was not required to take a polygraph test as a condition for proceeding with a sexual abuse investigation.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 23 and 24, section O(1)(d) and (f) address 115.271(f).

The auditor's review of the afore-mentioned administrative investigation reports reveals substantial compliance with 115.271(f).

According to the investigative staff interviewee, she assesses staff actions for culpability during each sexual abuse investigation. This includes an assessment as to whether staff's actions or failure to act contributed to the sexual abuse.

The interviewee also asserts administrative investigations are documented in written reports. Reports include an analysis of interview notes, video analysis, evidentiary analysis, physical evidence analysis, credibility analysis, and file review results. A conclusion is also developed and documented.

According to the investigative staff interviewee, criminal investigation reports are documented. They are very similar to administrative reports, in assembly and appearance.

The auditor was not able to review any criminal reports during the audit process. Pursuant to the PAQ, the Director self reports substantiated allegations of conduct that appear to be criminal are referred for prosecution. The Director further self reports there were no substantiated allegations of conduct that appeared to be criminal that were referred for prosecution since the last PREA audit. However, the auditor finds El Paso Sheriff's Department investigators were involved in the investigative process regarding three of the seven sexual abuse investigations conducted during the last 12 months. Of note, in one of these cases, the alleged victim refused to provide information to the administrative Investigator and instead, pursued criminal charges.



According to the investigative staff interviewee, sexual abuse matters are generally assessed and discussed with El Paso Sheriff's Department investigators. Evidence is preemptively assessed to determine if the same reaches the standard of proof necessary to support a criminal finding. Additionally, the fact pattern is assessed to determine whether the same is commensurate with statute.

Pursuant to the PAQ, the Director self reports the agency retains all written reports referenced in the above paragraphs of this section for as long as the alleged abuser is incarcerated or employed by the agency, plus five years.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 29, section T(1) addresses 115.271(i). The afore-mentioned retention schedule clearly substantiates compliance with 115.271(i).

The auditor's review of the afore-mentioned administrative investigation reports reveals substantial compliance with 115.271(i).

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 23, section O addresses 115.271(j). This policy stipulates the Director shall ensure an administrative investigation or referral for a criminal investigation, where appropriate, is completed for all allegations of sexual abuse or sexual harassment.

According to the investigative staff interviewee, the investigation continues when either a staff member alleged to have committed sexual abuse terminates employment prior to a completed investigation into his/her conduct or when a victim who alleges sexual abuse or sexual harassment or an alleged abuser leaves the facility prior to completion of an investigation into the matter.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 24, section O(2)(a)(i), (b) and (c) addresses 115.271(l).

According to the Director, staff do maintain contact with EPSD to determine if administrative investigation can continue or if it can be initiated. The Director takes the lead. If he is unavailable, the Assistant Director or Learning Development Manager (Investigator) makes weekly contact. According to the investigative staff interviewee, she provides the outside investigative agency as much support and assistance as requested and possible. She continues with the administrative investigation, simultaneous with the criminal investigation, unless directed otherwise. She does not close the administrative investigation until the criminal investigation is closed.

The auditor recommends these weekly contacts be documented in an effort to ensure a continuous paper trail preemptive of resident or staff notifications.

In view of the above, the auditor finds EPTC to be substantially compliant with 115.271.

## 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*)

Pursuant to the PAQ, the Director self reports the agency imposes 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 26, section O(5) addresses 115.272(a).

The investigative staff interviewee asserts the agency uses, as the standard of evidence for substantiation of allegations of sexual abuse or sexual harassment, a preponderance of the evidence.

The auditor's review of the previously mentioned seven administrative sexual abuse investigations conducted during the last 12 months reveals substantial compliance with 115.272(a).

In view of the above, the auditor finds EPTC to be substantially compliant with 115.272.

## Standard 115.273: Reporting to residents

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

### 115.273 (a)

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

### 115.273 (b)

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

#### 115.273 (e)

- Does the agency document all such notifications or attempted notifications? X  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*)

Pursuant to the PAQ, the Director self reports 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. The Director further self reports three criminal and/or administrative investigations of sexual assault were conducted at EPTC during the last 12 months and three victims were notified of the results of the respective investigations.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 26, section Q(1) addresses 115.273(a).

The auditor's review of seven sexual assault investigations (four administrative and three criminal investigations) conducted during the last 12 months, reveals three notifications were issued to residents pursuant to 115.273. In two additional cases, the alleged victim absconded, returned to the facility for a brief period of time, and was arrested (first case) and the resident in the second case absconded six days following the report. The second resident was away from the facility from April 19, 2018 through July 27, 2018. In view of the above, the auditor finds EPTC to be compliant with 115.273(a).

According to the Director, the facility does notify a resident who makes an allegation of sexual abuse when the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation. A specific notification form is used. Upon conclusion of the investigation, the assigned Investigator meets with the resident, issues the afore-mentioned form, and discusses the same with the resident.

According to the investigative staff interviewee, agency procedures require that a resident who makes an allegation of sexual abuse must be informed as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation. She asserts the Director handles notifications.

Pursuant to the PAQ, if an outside entity conducts such investigations, the agency requests the relevant information from the investigative entity in order to inform the resident of the outcome of the investigation. The Director further self reports 0 criminal investigations were facilitated by the El Paso Sheriff's Department during the last 12 months.

The auditor's review of three of the seven investigations reveals they were referred to the El Paso Sheriff's Department. Findings of Unsubstantiated and Unfounded were determined in two of the cases. The third is pending.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 26, section Q(1) addresses 115.273(b).

Pursuant to the PAQ, the Director self reports that following a resident's allegation a staff member has committed sexual abuse against the resident, the facility subsequently informs the resident (unless the agency has determined the allegation is unfounded) whenever:

The staff member is no longer posted within the resident's unit;

The staff member is no longer employed at the facility;

The agency learns the staff member has been indicted on a charge related to sexual abuse within the facility; or

The agency learns the staff member has been convicted on a charge related to sexual abuse within the facility.

The Director further self reports there has been a substantiated or unsubstantiated complaint of sexual abuse committed by a staff member against a resident at EPTC in the last 12 months.

The auditor's review of the afore-mentioned investigations reveals there has been two staff-on resident allegations during the last 12 months. One allegation was determined to be Unfounded while the other was Unsubstantiated. With respect to the administrative Unsubstantiated allegation, notification was provided however, the resident refused to sign. It is noted a subsequent criminal finding, regarding the same allegation, was Unfounded.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 26, section Q(2)(a-d) addresses 115.273(c).

Pursuant to the PAQ, following a resident's allegation he or she has been sexually abused by another resident at EPTC, the agency subsequently informs the alleged victim whenever:

The agency learns 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 26, section Q(3)(a and b) addresses 115.273(d).

According to the Director, the agency has not learned of any circumstances fitting the narrative of 115.273(d).

Pursuant to the PAQ, the Director self reports the agency has a policy that all notifications to residents described under this standard are documented. The Director further self reports 0 written notifications were provided to the alleged victims, as stated above, during the last 12 months. Both notifications were documented.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 27, section Q(4) addresses 115.273(e).

The auditor's review of the Resident PREA Allegation Status Notifications are articulated in the preceding paragraphs.

In view of the above, the auditor finds EPTC to be substantially compliant with 115.273.

## 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*)

Pursuant to the PAQ, the Director self reports staff is subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 28, section 2(a) addresses 115.276(a).

Pursuant to the PAQ, the Director self reports in the past 12 months, 0 facility staff have violated agency sexual abuse or sexual harassment policies.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 28, section 2(a) addresses 115.276(b).

Pursuant to the PAQ, the Director self reports 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 28, section 2(b) addresses 115.276(c).

Pursuant to the PAQ, the Director self reports 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, unless the activity was clearly not criminal, and to any relevant licensing bodies. The Director further self reports during the last 12 months, 0 facility staff have been reported to law enforcement or licensing boards following termination (or resignation prior to termination) for violating agency sexual abuse or sexual harassment policies.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 28, section 2(c) addresses 115.276(d).



As previously indicated, one allegation of sexual abuse was referred to El Paso Sheriff's Department after being determined to be Unsubstantiated administratively. The allegation was subsequently determined to be Unfounded pursuant to criminal investigation. Another such allegation was also determined to be Unfounded.

Pursuant to the PAQ, the Director self reports staff is subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 27, section Q(4) addresses 115.276(e).

Pursuant to the PAQ, the Director self reports in the past 12 months, 0 facility staff have violated agency sexual abuse or sexual harassment policies.

The auditor finds EPTC to be substantially compliant with 115.276.

## **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*)

Pursuant to the PAQ, the Director self reports agency policy requires 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. Additionally, the Director self reports agency policy requires any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents. According to the Director, in the past 12 months, no contractors or volunteers have been reported to law enforcement agencies and relevant licensing bodies.  
CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 29, section R(3) addresses 115.277(a).

Pursuant to the PAQ, the Director self reports 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 29, section R(3) addresses 115.277(b).

According to the Director, in the event of any violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, the contracting agency is notified of pending PREA allegation and the alleged perpetrator is removed from the facility pending, minimally, conclusion of the investigation.

The auditor finds EPTC to be substantially compliant with 115.277.

## **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? X  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? X  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? X  Yes  No

#### 115.278 (d)

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

#### 115.278 (e)

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

#### 115.278 (f)

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

#### 115.278 (g)

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

#### Auditor Overall Compliance Determination

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

Pursuant to the PAQ, the Director self reports residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding the resident engaged in resident-on-resident sexual abuse. The Director further self reports residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following a criminal finding of guilt for resident-on-resident sexual abuse. Although there were investigations as articulated above, in the past 12 months, there were 0 administrative and criminal findings of resident-on-resident sexual abuse that occurred at the facility.

The auditor's review of one resident-on-resident sexual abuse investigation reveals the same was Substantiated.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 27, section R(1)(a)(i) addresses 115.278(a).

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 27, section R(1)(a)(iii) addresses 115.278(b).

According to the Director, Parole or Probation authorities facilitate all disciplinary hearings in accordance with TDCJ regulations.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 27, section R(1)(a)(iv) addresses 115.278(c).

Pursuant to the PAQ, the Director self reports the facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse. In view of the above, facility staff considers whether to require the offending resident to participate in such interventions as a condition of access to programming or other benefits.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 28, section R(1)(c) addresses 115.278(d). This policy stipulates if deemed to be a sexual offender, the resident will be required to attend classes designated by Parole authorities.

Of note, the Director advises, in a separate conversation, that EPTC residents are under Parole/Probation supervision, as opposed to, a continuation of their prison sentence. Many residents are working on their Parole Plan, inclusive of housing, educational, vocational, and work plans. Accordingly, programming assignments fall under the jurisdiction of Parole/Probation authorities.

According to the medical interviewee, therapy, counseling, or other intervention services designed to address and correct the underlying reasons or motivations for sexual abuse are completed at University Medical Center or CASFV. The interviewee further asserts EPTC staff do not require a resident's participation in such services as a condition of access to programming or other benefits.

Pursuant to the PAQ, the Director self reports the agency disciplines residents for sexual conduct with staff only upon finding that the staff member did not consent to such contact.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 27, section R(1)(a)(v) addresses 115.278(e).

Pursuant to the PAQ, the Director self reports the agency prohibits 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 27, section R(1)(b)(i) addresses 115.278(f).

Pursuant to the PAQ, the Director self reports the agency prohibits all sexual activity between residents.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 27, section R(1)(a)(vi) addresses 115.278(g).

The Handbooks provided do not cover all areas addressed by this standard. For example, mental health/ mental illness, report of sexual abuse made in good faith, etc. are not addressed. The auditor recommends the EPTC PCM include relevant information from provisions of 115.278 in an amended Resident Handbook.

The auditor finds EPTC to be substantially compliant with 115.278.

## 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?  
X  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? X  Yes  No
- Do security staff first responders immediately notify the appropriate medical and mental health practitioners? X  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? X  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? X  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*)

Pursuant to the PAQ, the Director self reports resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The Director further self reports the nature and scope of such services are determined by medical and mental health practitioners according to their professional judgment. Additionally, the Director reports that as medical care, other than distribution of medication and basic intervention, is not provided at EPTC, such secondary materials are maintained at the hospital. Similarly, mental health documentation is not maintained at EPTC.

The medical staff interviewee reports resident victims of sexual abuse receive timely and unimpeded access to emergency medical treatment and crisis intervention services. The interviewee asserts Medical staff are not immediately notified of sexual assault cases. Medical does not normally play a role in assessing for referral to a hospital. Follow-up services are provided at UMC.

Auditor's Note: Medical staff at EPTC have limited practice privileges and accordingly, the role appears to be different than what one would see in a prison or jail.

The resident who reported a sexual abuse interviewee asserts he refused medical treatment in follow-up to his report of sexual abuse.

The auditor's review of the Sexual Abuse Check Sheet relative to the seven sexual abuse allegations occurring within the last 12 months reveals no removal of the victims from the facility to a local hospital for follow-up medical intervention. As mentioned above, one interviewee declined medical treatment.

Three of the six random security first responders report they contact medical staff as part of their First Responder duties. The non-security interviewee also identified medical staff as part of the First Responder duties. However, the auditor notes, as reflected above, the role of Medical staff is limited in terms of their role in this process.

As previously mentioned in the narrative for 115.264, all staff receive the same First Responder training and all staff receive the CC First Responder card. Additionally, the auditor's determination regarding the requirements of 115.264 and requirement for training are thoroughly discussed in that provision. The auditor finds no basis for a non-compliance finding with respect to the subject-matter of that provision and consequently, 115.282.

The MOU between CC and CASFV, page 3, section B(9) addresses this provision. Additionally, the Coordinated Response addressed in the narrative for 115.265 clearly addresses duties and responsibilities to ensure appropriate, comprehensive, and timely treatment for sexual abuse victims.

Pursuant to the PAQ, the Director self reports resident victims of sexual abuse while incarcerated are 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.

The MOU between CC and University Medical Center of El Paso, page 2, section B(6) addresses this provision.

The medical staff interviewee asserts victims of sexual abuse are offered timely information about access to emergency contraception and sexually transmitted infection prophylaxis via SANE Nurses at UMC.

As the resident who reported a sexual abuse interviewee refused medical treatment in follow-up to his report of sexual abuse, he could not be offered timely information about access to emergency contraception and sexually transmitted infection prophylaxis.

Pursuant to the PAQ, the Director self reports 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 25, section 4(c) addresses 115.282(d).

The MOU between CC and University Medical Center of El Paso, page 2, section B(2) addresses this provision. It is noted, however, this document is not signed by both parties.

The auditor finds EPTC to be substantially compliant with 115.282.

## **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? X  Yes  No

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



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

#### 115.283 (c)

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

#### 115.283 (d)

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

#### 115.283 (e)

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

#### 115.283 (f)

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

#### 115.283 (g)

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

#### 115.283 (h)

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

#### Auditor Overall Compliance Determination

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

Pursuant to the PAQ, the Director self reports the facility 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 25, sections 4(c and d) partially address 115.283(a). Specifically, forensic examinations are addressed however, there is no reference to historical sexual assaults that may have occurred in any prison, jail, lockup, or juvenile facility.

Similarly, there are no policy provisions regarding mental health follow-up in such situations. Provisions 115.283(f) and (h) are also absent policy references, as well as, guidance as to how facility staff accomplish such tasks. As an example, given the fact there are no mental health providers on staff at EPTC, how are referrals for mental health evaluations of resident-on-resident sexual abusers accomplished and is there a monitoring process to facilitate the same? See 115.283(h).

In view of the above, the auditor finds EPTC to be non-compliant with 115.283. Accordingly, EPTC will be subject to a 180-day corrective action period, concluding on or about April 6, 2019. Of note, this finding can be closed prior to conclusion of the maximum corrective action period at the auditor's discretion.

During the corrective action period, the EPTC PCM and Director will develop policy to address 115.283(a), as well as, the other afore-mentioned standard provisions. Policy formulation must be accomplished in accordance with CC guidelines. Subsequent to completion of the policy or addendum to CC Policy 14.2 CC, the same will be forwarded to the auditor for review. Upon approval by the auditor and in accordance with CC policy, practice, and procedure, the policy will be institutionalized pursuant to training of relevant stakeholders. A copy of the lesson plan and signed/dated copies of relevant training certifications bearing the "I understand" caveat will be forwarded to the auditor for retention in the EPTC audit file.

#### **September 26, 2018 Update:**

**The auditor's review of a draft policy update capturing the requirements as articulated above reveals, upon implementation, the intent of the standard will be met.**

#### **November 29, 2018 Update:**

**The auditor has been advised the above policy was implemented on September 25, 2018. The auditor's review of training documentation reveals 33 staff have been trained regarding this policy and implementation of the same. The EPTC Director certifies completion of the training and relevant documentation does include the "I understand" caveat.**

**In view of the above, the auditor finds EPTC is now compliant with 115.283.**

Additionally, the EPTC PCM will forward copies of completed sexual abuse investigations, inclusive of medical documentation substantiating compliance with the newly issued policy(ies) and

115.283, throughout the corrective action period. The auditor will review each packet for standard compliance, ensuring follow-up regarding any non-compliance issues, if applicable. The auditor finds the MOU between CC and University Medical Center of El Paso, page 2, section B(2) does address this provision.

Page 2, section B(7) of the CC MOU with the University Medical Center of El Paso vaguely addresses 115.283(c). Page 3, section B(10) of the CASFV MOU, also addresses 115.283(b) from a mental health treatment perspective.

The medical staff interviewee asserts evaluation and treatment of residents who have been victimized would entail, if she was involved, a complete visual inspection of the victim, assessment of scratches/bruises/etc. and documentation of the same, recording of vitals, keeping the resident victim calm, and ensuring no evidence destruction.

The medical staff interviewee reports medical and mental health services are offered consistent with the community level of care as victims are transferred to UMC for the same.

EPTC is an all-male facility and accordingly, 115.283(d) is not applicable.

EPTC is an all-male facility and accordingly, 115.283(e) is not applicable.

Pursuant to the PAQ, the Director self reports resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate.

Page 2, section B(6) of the CC MOU with the University Medical Center of El Paso addresses 115.283(f).

Pursuant to the PAQ, the Director self reports treatment services are provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 25, section 4(c) addresses 115.283(g).

Pursuant to the PAQ, the Director self reports the facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history, and offers treatment when deemed appropriate by mental health practitioners. Of note, there are no mental health practitioners at EPTC. Reportedly, services are provided in the community or at UMC.

In view of the above, the auditor finds EPTC substantially compliant with 115.283.

## 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*)

Pursuant to the PAQ, the Director self reports the facility conducts a sexual abuse incident review at the conclusion of every criminal or administrative sexual abuse investigation, unless the allegation has been determined to be unfounded. The Director further self reports in the past 12 months, 0 criminal and one administrative sexual abuse investigations were facilitated at EPTC.

As previously reflected in the narrative for 115.271, the auditor reviewed seven administrative or criminal sexual assault investigations pertinent to EPTC. Three investigations were handled as criminal investigations (in one of these cases, the resident chose to press charges) and four were handled as administrative investigations. One of the administrative investigations was determined to be Unfounded and accordingly, a SART was not warranted.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 23, section N(1) addresses 115.286(a).

The auditor's review of the six applicable Sexual Abuse or Assault Incident Review Forms relative to the afore-mentioned EPTC sexual abuse allegations reveals substantial compliance with 115.286(a) and (b). Reviews were timely in accordance with the afore-mentioned provisions.

Pursuant to the PAQ, the Director self reports the facility ordinarily conducts a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation. The Director further self reports in the past 12 months, 0 criminal or administrative sexual abuse investigations were facilitated at EPTC.

The number of applicable investigations is addressed in preceding paragraphs. As previously noted, SART reviews were timely.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 23, section N(1)(b) addresses 115.286(b).

Pursuant to the PAQ, the Director self reports the sexual abuse incident review (SART) team includes upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 23, section N(1)(a) addresses 115.286(c).

The Director asserts there is a SART team at EPTC. Additionally, the Director asserts the team includes upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners.

The auditor's review of the reports mentioned in the narrative for 115.286(a) reveals substantial compliance with 115.286(c) based on the positions represented on the review teams.

Pursuant to the PAQ, the Director self reports the facility prepares a report of its findings from sexual abuse incident reviews, including but not necessarily limited to, determinations made pursuant to paragraphs (d)(1)-(d)(5) of this provision and any recommendations for improvement, and submits such report to the facility head and PREA Coordinator.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 23, section N(2)(a-e) and N(3) address 115.286(d).

The auditor's review of reports addressed in the narrative for 115.286(a) reveals substantial compliance with 115.286(d). All tenets of 115.286(d) are addressed in detail in a well written and well-analyzed fashion. Requisite distribution of the report is reflected on the form. In all cases, either/or the EPTC Director, Assistant Director, as well as, the facility Investigator and other staff were members of the review teams.

The Director asserts the information gleaned from SART reviews is used to evaluate "steps missed", policy revision needs, potential facility changes, and potential programming changes. The Director further asserts the review team: 1. Considers whether the incident or allegation was motivated by race, ethnicity, gender identity, or LGBTI status; 2. Examines the area of the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; 3. Assesses the adequacy of staffing levels in that area during different shifts; and 4. Assesses whether monitoring technology should be deployed or augmented to supplement supervision by staff. A report regarding findings is prepared, addressing the afore-mentioned issues and any recommendations for improvement, and is subsequently submitted to the EPTC PCM and him. All recommendations are considered.

The EPTC PCM asserts she is part of every SART. She reviews all SART reports and findings and follows up on recommendations. In reference to trends regarding sexual abuse, the EPTC PCM did not cite anything specific.

The SART review team interviewee asserts the previously mentioned questions/issues (reflected in the Director's interview narrative) are addressed by the SART team.

Pursuant to the PAQ, the Director self reports the facility implements the recommendations for improvement or documents its reasons for not doing so.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 23, section N(4)addresses 115.286(e).

The auditor finds EPTC to be substantially compliant with 115.286.

## 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*)

Pursuant to the PAQ, the Director self reports the agency collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. The Director further self reports the standardized instrument includes, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 29, section T(1)(a)(i) addresses 115.287(a/c).

Pursuant to the PAQ, the Director self reports the agency aggregates the incident-based sexual abuse data at least annually.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 29, section T(1)(a)(ii) addresses 115.287(b).

The auditor's review of the 2017 Annual Report reflects the data was aggregated for the report.

Pursuant to the PAQ, the Director self reports the agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 29, section T(1) addresses 115.287(d).

EPTC does not contract with any other facility(ies) for confinement of its residents. and accordingly, the auditor finds 115.287(e) to be not applicable to EPTC.

Pursuant to the PAQ, the Director self reports the agency provided the Department of Justice with data from the previous calendar year upon request. However, the CCPC advises the facility did not provide such information.

The auditor finds EPTC to be substantially compliant with 115.287.

## 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*)

Pursuant to the PAQ, the Director self reports the agency reviews 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 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 corrective actions for each facility, as well as, the agency as a whole.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 30, section 3(a)(i-iii) addresses 115.288(a).

The auditor's review of the 2017 CC Annual Report reveals substantial compliance with 115.288(a-c). The report is published on the CC website. Specifically, the report reflects a comparison of the current year's data and corrective actions with those from prior years and an assessment of the agency's progress in addressing sexual abuse. Additionally, the report is approved by the CC Executive Vice President and Chief Corrections Officer.

The Agency Head interviewee advises CC accesses information from several sources, using incident-based sexual abuse data to assess and improve sexual abuse prevention, detection, and response policies, practices, and training. Specifically, he advises that a 5-1 Incident Reporting System is implemented wherein incidents and reports are, minimally, reviewed by Corporate and designated facility staff within a 24-hour period. Monthly, a report of PREA related incidents details frequency and location(s) of incidents within the facility, amongst other criteria. Pursuant to this procedure, Corporate and facility staff collaborate to diagnose any PREA-related issues, concerns, etc. These proactive steps, in addition to SART review findings and continual monitoring of data, are utilized to attain optimal efficiency in terms of sexual safety of residents at CC facilities.

In view of the above, the auditor finds EPTC to exceed compliance expectations with respect to 115.288. This procedure is representative of CC's commitment and zeal in terms of enhancement of resident sexual safety within facilities.

While the CCPC interviewee was not interviewed during this audit, his statement with respect to previous CC audits is noteworthy. He asserts the agency does review data collected and aggregated in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies and training. Such data is securely retained in password protected programs at both the facility and CCPC's office. Access to this information is limited.

Auditor's Note: PREA investigation reports and ancillary documentation are electronically generated however, a safely secured filing cabinet is located in the Compliance Manager's and Investigator's offices. The auditor observed these processes throughout the on-site audit. The CCPC further advises the agency takes corrective action on an ongoing basis based on this data. For example, anything identified pursuant to a mock audit or SART review is considered for implementation.

The EPTC PCM advises PREA investigations are electronically forwarded to the CCPC and Corporate maintains the paper trail. Corporate maintains relevant statistics and makes effectiveness assessments. Additionally, the CC annual report is promulgated at Corporate.

Pursuant to the PAQ, the Director self reports the annual report includes a comparison of the current year's data and corrective actions with those from prior years. The Director further self reports the annual report provides an assessment of the agency's progress in addressing sexual abuse.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 30, section 3(b) addresses 115.288(b).

Pursuant to the PAQ, the Director self reports the agency makes its annual report readily available to the public at least annually through its website and the annual reports are approved by the agency head.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 30, section 3(c) addresses 115.288(c).

According to the Agency Head interviewee, he reviews all PREA Annual Reports as he is the direct supervisor of the CCPC. He copiously reviews each report for comprehensiveness and content, forwarding the same to the CC Chief Corrections Officer for final review and signature.

Pursuant to the PAQ, the Director self reports 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. Furthermore, the agency indicates the nature of the material redacted.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 30, section 3(d) addresses 115.288(d).

The EPTC PCM asserts redactions are handled by the CCPC. Again, while not interviewed, the CCPC's statement (previous CC facility audits) in this regard is noteworthy. According to the CCPC interviewee, CC rarely redacts information from aggregated reports, etc. All data is collected in generic fashion.

As previously indicated, the auditor finds EPTC to exceed standard expectations regarding 115.288.

## **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?  
X  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*)

Pursuant to the PAQ, the Director self reports the agency ensures that incident-based and aggregated data are securely retained.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 29, section T(1)(a)(iv) addresses 115.289(a).

The EPTC PCM advises PREA investigations are electronically forwarded to the CCPC and Corporate maintains the paper trail. Corporate maintains relevant statistics and makes effectiveness assessments. Additionally, the CC annual report is promulgated by Corporate staff.

Secure storage of data is addressed in the narratives for 115.287 and 115.288.

Pursuant to the PAQ, the Director self reports agency policy requires that aggregated sexual abuse data from facilities under its direct control and private facilities with which it contracts be made readily available to the public, at least annually, through its website.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 30, section (c)(i) addresses 115.289(b).

The auditor's review of the CC website reveals aggregated sexual abuse data is available on an annual basis.

Pursuant to the PAQ, the Director self reports before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 30, section (c)(ii) addresses 115.289(c).

Pursuant to the PAQ, the Director self reports 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.

The auditor's review of the CC Records Retention Schedule reveals compliance with 115.289(d).

The auditor finds EPTC to be substantially compliant with 115.289.

## 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.*) X  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.) X  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?  
X  Yes  No

#### 115.401 (i)

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

#### 115.401 (m)

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

#### Auditor Overall Compliance Determination

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

The auditor notes EPTC staff were very facilitative throughout the Pre-Audit, On-Site Audit, and Post-Audit phases of this review. Expeditious efforts to ensure a smooth interview process were extremely beneficial to the auditor.

#### Standard 115.403: Audit contents and findings

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

#### 115.403 (f)

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

The auditor's review of the CC website confirms compliance with this provision.

## AUDITOR CERTIFICATION

I certify that:

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

### Auditor Instructions:

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

K. E. Arnold

January 4, 2019

**Auditor Signature**

**Date**

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

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