Prison Rape Elimination Act (PREA) Audit Report
Juvenile Facilities

☐ **Interim** ☒ **Final**

Date of Report February 10, 2020

Auditor Information

Name: Lawrence Howell	**Email:** Lawrencewhowell@gmail.com
Company Name: N/A	
Mailing Address: 11700 W Charleston Blvd #170-529	**City, State, Zip:** Las Vegas, NV 89135
Telephone: (775) 721-2972	**Date of Facility Visit:** August 28, 29, 30, 2019

Agency Information

Name of Agency Everyday Life Inc. Residential Treatment Center		**Governing Authority or Parent Agency** *(If Applicable)* Not Applicable	
Physical Address: 6955 Branch Road		**City, State, Zip:** Bryan, Texas 77808	
Mailing Address: Same		**City, State, Zip:** Same	
The Agency Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

Agency Website with PREA Information: www.everydaylifertc.com

Agency Chief Executive Officer

Name: Fred Payton, Chief Executive Officer	
Email: SJSUDB@aol.com	**Telephone:** (979) 412-0570

Agency-Wide PREA Coordinator

Name: Cedric Payton, Director of Administration / PREA Coordinator	
Email: cedricpayton@msn.com	**Telephone:** (979) 412-3891
PREA Coordinator Reports to: Executive Director Click or tap here to enter text.	**Number of Compliance Managers who report to the PREA Coordinator: 0** Click or tap here to enter text.

Facility Information

Name of Facility: Everyday Life Inc. Residential Treatment Center			
Physical Address: 6955 Broach Road		**City, State, Zip:** Bryan, Texas 77808	
Mailing Address (if different from above): Same		**City, State, Zip:** Same	
The Facility Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

Facility Website with PREA Information: www.edlrtc.com

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

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

☐ ACA

☐ NCCHC

☐ CALEA

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

☒ N/A

If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe:
The facility has completed routine licensing audits as required by local regulation.

Facility Administrator/Superintendent/Director

Name:	Cedric Payton, Director of Administration / PREA Manager		
Email:	cedricpayton@msn.com	**Telephone:**	(979) 412-3891

Facility PREA Compliance Manager

Name:	Cedric Payton, Director of Administration / PREA Coordinator		
Email:	cedricpayton@msn.com	**Telephone:**	(979) 412-3891

Facility Health Service Administrator ☒ N/A

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

Facility Characteristics		
Designated Facility Capacity:	36	
Current Population of Facility:	26	
Average daily population for the past 12 months:	32.92	
Has the facility been over capacity at any point in the past 12 months?	☐ Yes ☒ No	
Which population(s) does the facility hold?	☐ Females ☒ Males ☐ Both Females and Males	
Age range of population:	8-17	
Average length of stay or time under supervision	6 months	
Facility security levels/resident custody levels	Medium Restriction	
Number of residents admitted to facility during the past 12 months		96
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:		96
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *10 days or more:*		96
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?		☐ Yes ☒ No
Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):	☐ Federal Bureau of Prisons ☐ U.S. Marshals Service ☐ U.S. Immigration and Customs Enforcement ☐ Bureau of Indian Affairs ☐ U.S. Military branch ☐ State or Territorial correctional agency ☐ County correctional or detention agency ☐ Judicial district correctional or detention facility ☐ City or municipal correctional or detention facility (e.g. police lockup or city jail) ☐ Private corrections or detention provider ☐ Other - please name or describe: Click or tap here to enter text. ☒ N/A	
Number of staff currently employed by the facility who may have contact with residents:		22
Number of staff hired by the facility during the past 12 months who may have contact with residents:		2

Number of contracts in the past 12 months for services with contractors who may have contact with residents:	0
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	8
Number of volunteers who have contact with residents, currently authorized to enter the facility:	0
Physical Plant	
Number of buildings: **Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.**	6
Number of resident housing units: **Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.**	3
Number of single resident cells, rooms, or other enclosures:	0
Number of multiple occupancy cells, rooms, or other enclosures:	0
Number of open bay/dorm housing units:	3
Number of segregation or isolation cells or rooms (for example, administrative, disciplinary, protective custody, etc.):	2
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	☐ Yes ☒ No
Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	☐ Yes ☒ No

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

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

Audit Findings

Audit Narrative

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

Everyday Life Residential Treatment Center (EDL) is located at 6955 Broach Road in Bryan Texas. EDL is a non-profit 501 © 3 organization governed by a Board of Directors and managed daily by an experienced on-site management team. The PREA Audit of Everyday Life Residential Treatment Center (EDL) was conducted over three days – August 28, 29, and 30, 2019. This audit followed the facilities first PREA audit that took place May 25,26,27, 2016. The 2019 PREA audit team consisted of Lawrence Howell (probationary status and lead auditor) and Jerome K. Williams (fully certified auditor) assisted. The audit contract was executed on June 7, 2019 between Lawrence Howell and Everyday Life, Inc.

Throughout the audit, the PREA audit team found the site management team to be responsive to auditor requests and knowledgeable about the PREA standards. No barriers to completing the audit were experienced.

The audit was conducted in three distinct phases: the pre-onsite audit, the onsite audit, and the post-audit phase.

Pre On-Site Audit Phase

Pre On-Site audit methodology included four core activities conducted by auditors Howell and Williams:

1. Audit planning and logistics
2. Posting notice of the audit
3. Reviewing facility policies, procedures, and documentation
4. Conducting outreach to advocacy organizations

During the pre-onsite phase both PREA auditors met with Executive Director Cedric Payton by phone and conducted a "kick-off" call. The phone meeting was conducted on June 24, 2019. During the call the following was discussed:

a. Introductions of the PREA audit and facility management team members. The discussion focused on everyone's role in the audit process.
b. Explanation of the PREA Audit process, timelines, purpose of corrective action to improve practices, and the overall goal of a successful final PREA report.
c. Logistics, unimpeded access to the facility and staff during the on-site phase, documents that would be needed to complete the audit.
d. Agreement on the best form of communication (e-mail and telephone) and schedule for continued communications.
e. Goals, timeline expectations, and objectives of the PREA audit of Everyday Life Residential Treatment Center.
f. Notice of audit posting and timeline requirements. Discussion included steps necessary to maintain resident confidentiality in communicating with the auditors.

On June 26, 2019 lead PREA auditor Lawrence Howell followed the “kick off” meeting with a memo summarizing the meeting, the PREA process map, and the documentation required by the facility before the on-site audit phase.

Because this was Everyday Life’s 3-year audit (original audit was May 25-27, 2016) the facility management staff were familiar with the process as a “paper audit,” therefore the overall audit method was “paper” instead of the PREA On-line Audit System (OAS). During the pre-onsite phase, facility management staff gathered documents, completed the Pre-Audit Questionnaire (PAQ), and sent the information to Lawrence Howell cc’d Jerome Williams. During this phase, communication between the auditors and the facility managers included four phone calls, the mailing of an external “jump” drive that included requested documents, and numerous e-mails and text messages.

Lead Auditor Lawrence Howell provided the required notice of audit posting with his name, address, and phone number. Directions regarding how and where to post the notice of audit were also provided. Proof, in the form of pictures, of the audit notice being posted at least 6 weeks in advance of the audit was received from Cedric Payton on July 9, 2019 (7 weeks in advance of the on-site audit). Pictures included proof of posting in cottages 1,2, and 3, as well as the Administration building lobby area, and the EDL Directors office. During the on-site phase of the audit, auditors Howell and Williams observed and verified the notice of audit posted on colored paper in the following locations:

a. Administration building lobby
b. Administration hallway
c. Youth cottages 1,2, and 3
d. Dining areas
e. EDL Directors Office

Lead Auditor Lawrence Howell also conducted a search of the internet for any PREA/Everyday Life related incidents. There were news articles about the facility and incidents, but no news articles or law enforcement reports related to sexual abuse or sexual harassment were found. A review of the agency website was conducted. The agency web site (located at www.everydaylifertc.com) included the EDL Zero Tolerance Policy, the 2016 Interim PREA Audit Report, and how to anonymously report an allegation of sexual abuse or sexual harassment. One phone number listed is direct to the EDL Directors office (979) 412-3891 and one phone number for reports directly to Texas Department of Family Protective Services (TDFPS) at (800) 252-5400. Also listed was the e-mail address of the EDL Director, Cedric Payton.

Lawrence Howell called the Sexual Assault Resource Center (SARC), Chief Deputy Jim Stewart at the Brazos County Sheriff’s Office, Scotty’s House Child Advocacy Center, and Niki Johnson at the Sexual Assault and Violence Response Team and Child Protection Team at Baylor Scott & White Health Hospital to confirm their role with PREA and Everyday Life Residential Treatment Center and to inquire about any allegations or investigations during the past three years. The community partners confirmed both their current existing working relationships with Everyday Life Residential Treatment Center and that they were not aware of any PREA related allegations or investigations during the past 12 months. Upon further questioning no one reported allegations or investigations during the past 3 years.

Prior to the on-site phase of the audit, the auditors reviewed all documentation submitted by the facility and developed an “issue log” of items that deserved additional follow up or clarification. The issue log tool process was used to identify gaps and missing information. The issue log was e-mailed to the facility management team. In response to the issue log there were discussions and additional documents provided prior to the on-site phase of the audit. Items requested prior to the on-site portion of the audit were as follows:

1. Pre-Audit Questionnaire (PAQ) - The paper PAQ was discussed at the Kick Off meeting and was received by the auditors on July 17, 2019
2. Description of the agency and facility
3. Organizational Chart
4. PREA related posters, brochures, youth handbooks, and videos in English and Spanish
5. Staffing Plan
6. Facility schematics
7. Youth, staff, volunteer and contractors rosters including but not limited to;
    a) Complete list of youth
    b) Residents with disabilities
    c) Residents who are LEP
    d) Residents who identify as LGBTQI
    e) Residents in isolation was not applicable because EDL does not use isolation
    f) Residents in segregated housing was not applicable because EDL does not use segregation
    g) Residents who reported sexual abuse
    h) Residents who reported sexual victimization during risk screening
    i) Staff rosters including staff duties to identify specialized staff
    j) A list of all contractors that have contact with residents
    k) A list of all volunteers who have contact with residents
8. Grievances, allegations of sexual abuse and sexual harassment, all hotline calls made, and incidents from 12 months preceding the audit
9. Contracts/agreements with other residential facility providers
10. Memorandum of Understanding/Agreement with outside emotional support providers
11. Criminal and administrative investigative reports of sexual abuse and sexual harassment cases (since the last PREA audition 2016)
12. Investigative Flow Chart
13. Written Coordinated Response Plan
14. Sexual Abuse Review Team meeting minutes (for the last 12 months)
15. Everyday Life, Inc. Zero Tolerance Policy
16. Documents listed in the PREA Compliance Audit Tool Checklist of Policies/Procedures and Other Documents

Lead auditor Howell did not receive any confidential correspondence from residents, staff, contractors, or volunteers prior to, during the on-site, or during the post on-site phase of the audit.

On-Site Phase:

The audit methodology of the on-site phase included:

1. Site/Campus Review
2. Interviews of Staff and Residents
3. Documentation Selection and Review

On Wednesday August 28, 29, 30, 2019 the facility census was 26 youth. The on-site phase of the audit was conducted at 6955 Broach Road, Bryan Texas 77808. An entrance briefing meeting was attended by the following people:

a. Cedric Payton, Executive Director
b. Lorenza Wilson, Program Director
c. Lawrence Howell, Lead PREA Auditor

d. Jerome Williams, PREA Auditor

Entrance Meeting:
During the entrance meeting both auditors and facility managers introduced themselves and the group discussed the three-phase audit process and what the on-site phase would encompass. The facility managers explained facility staff roles, location of files and logs, and the location of the confidential interview rooms to be used during the audit. In addition, the facility managers provided the following documentation:

a) Current facility youth roster
b) Current facility staff roster
c) Current facility schedule
d) Facility census during the past 12 months
e) Video: Safeguarding Your Sexual Safety A PREA Orientation Video (English and Spanish)

Facility administrators, Cedric Payton and Lorenza Wilson, reiterated there had been zero sexual abuse and sexual harassment allegations in the past 12-month period. On August 28, 2019 Cedric provided auditor Howell with a signed written memorandum that included the language, “Everyday Life, Inc. General Residential Treatment Center is glad to report in regard to our PREA compliance and requirements, this agency has not had any sexual abuse/harassment allegations or complaints, noting date 08/2017 – 08/2019.

Further confirmation that there were no reported allegations of sexual abuse or harassment for the past 12 months was received during the interviews of the following individuals:

- Chief Deputy Jim Stewart of the Brazos County Sheriff’s Office Investigations Division
- Dana (no last name given) ID Agent #5005 of the TDFPS Hotline
- Brea (no last name given) of the Sexual Assault Resource Center
- Kevin Debose of the Texas Juvenile Justice Department Investigations Division.
- Niki Johnson, the sexual assault nurse examiner (SANE) at Baylor Scott & White Hospital

When contacted by phone, citing confidentiality laws, the Executive Director of the Sexual Assault Resource Center (SARC) would not confirm or deny any information about sexual assault or harassment allegations at EDL. She did confirm SARC would provide free advocacy, empowerment, and education services, in a confidential manner.

Because the pre-audit, on-site audit, and post audit document reviews, observations, and interviews confirmed there were zero allegations of sexual abuse or sexual harassment, the auditors could not review the following:

a) Total number of allegations 0
b) Number determined to be substantiated, unsubstantiated, or unfounded 0
c) Number of cases in progress 0
d) Number of criminal case investigations 0
e) Number of administrative case investigations 0
f) Number of criminal cases referred to prosecution, indicted, convicted or acquitted 0

Site Review / Facility Tour:
Following the entrance meeting, a detailed tour of the facility was provided by Executive Director Cedric Payton. The standards used to evaluate EDL facilities were those listed in the PREA Compliance Audit Tool – Instructions for PREA Audit Tour. There are six facility buildings, an outdoor paved basketball court, guest and staff parking lots, and extensive space for outdoor activities. Since the 2016 PREA audit, one building, a former dormitory used for storage, was demolished and removed. For specific detail including an overview

of the facility layout, description of the resident housing, and a detailed description of the general use areas of the campus see Facility Characteristics of this report. The facility schematic provided by facility management did match the campus layout toured. While on tour, both auditors had unimpeded access to all facility areas. Auditors observed the following areas including, but not limited to;

a) Administration building - offices, closets, bathrooms, reception, and intake office and meeting rooms. There were no areas of concern regarding the administration building. Student and staff records were observed stored in locking cabinets that were located in offices that had locking entrance doors. The area used for resident screening was in an office that was away from view from other residents and private/confidential screenings could take place.
b) Auditors observed locked grievance boxes in the resident cottages and the lobby of the administration building. Auditor Howell asked for the boxes to be opened to see if any written grievances were present. No grievances existed at that time. Auditor Howell and Williams asked both Cedric Payton and Lorenza Wilson to explain the grievance system process. As explained, the grievance system process was confidential, age appropriate, and could accommodate residents with learning disabilities or language barriers. During the resident interviews 13 of 13 residents stated they trusted the grievance system was fair, their concerns would be kept confidential, and they did not fear retaliation for filing a grievance.
c) Youth cottages as described in facility characteristics section of this report. The facility has three living cottages comprised of a kitchen area for food service that includes home-like storage cabinets, pantry and appliances. The dining/day room includes a dining table and couches facing a television screen. Two cottages have 16 open bay bunk beds (eight on each side of the building) and one cottage has six beds. The 16 bed cottages each have a time out room where youth can spend a self-placed time out period. Each sleeping area includes separate, single user bathroom and shower rooms. All closets and utility rooms remain locked and only the staff have access keys. Each youth has their own locker to store personal items. There were no areas of concern or blind spots in the resident cottages. Resident cottages included telephones. External reporting and sexual assault and sexual harassment emotional support services contact information were posted near the phones.
d) To ensure there is documentation that night staff stay awake there is a watchman's clock type system in place. Auditor Howell observed timecards that are issued to the night staff. As explained by Cedric Payton during the tour, every 15 minutes the staff are required to punch their timecard with a time clock that marks the day/time of the punch. Each morning the timecards are submitted to the supervisor so that the time periods between punches can be evaluated.
e) The tour concluded with a review of the outside activity areas, sports courts, fields, and parking areas. There were no concerns regarding the outside activity areas.
f) There were no surveillance cameras observed on the tour. This observation verifies management's report that surveillance cameras are not used at EDL.
g) Throughout the on-site audit PREA auditors observed the EDL staff practicing interactive supervision. The direct care staff to resident ratios were appropriate and staff were positioned where they could maximize resident supervision.

The entire Everyday Life facility was well maintained, clean, and showed nothing that would be a concern when considering resident sexual safety.

During the tour, auditors were given full access to all facility areas as requested including offices, counseling offices, youth sleeping areas, kitchens, living areas, dining areas, storage, bathrooms, shower rooms, closets and outside fields and basketball courts. During the tour both PREA auditors were able to randomly and informally interview residents and staff about their knowledge of the PREA standards. All of the residents interviewed, both in structured confidential interviews and during the facility tour, acknowledged the following:

1. Receiving an explanation of the facility's Zero Tolerance Policy upon admission
2. Receiving written information upon admission and watching the PREA video on a regular basis

3. Understanding the facility's Zero Tolerance Policy towards sexual harassment, sexual abuse, and their right to be free from retaliation for reporting sexual abuse or harassment allegations

There was not an actual intake/admission during the on-site audit. Auditors asked the intake staff to describe in detail how and where the intake, screening, and classification processes take place. Auditors reviewed the intake screening documents and received blank copies for the audit records. There were no items of concern regarding intake privacy, PREA education, or PREA notifications.

Staff Interviews:

EDL provided both auditor Howell and auditor Williams with private interview spaces in the administration building. Howell conducted interviews in a therapist office and Williams conducted interviews in a conference room. Both areas had closing doors and were out of view from other staff and residents.

19 of 32 total staff were interviewed. Eight specialized staff were interviewed, and eleven staff were randomly selected for interviews. The random staff interviewed included the following:

a. Male and female staff
b. Day and Night staff
c. New staff (hired in 2019) and veteran staff (hired before 2019)

The PREA interview protocols were used to ensure the proper questions were asked during the staff interviews. The number of staff and the correct positions that were interviewed corresponded with the standards listed in the PREA Auditor Handbook. Both Random and specialized staff were interviewed. Auditors received a staff roster showing names, tenure, position, and shift assignment. The selection process involved identifying and interviewing specialized staff to match the protocol requirements and selecting as many random staff that were available on the dates August 28 and 29, 2019.

Staff Interviews	Minimum Required	Completed
Agency Head / Contract Administrator / Facility Head /PREA Coordinator / Retaliation Monitoring	1	1
Program Director / Retaliation Monitoring / Intake / Unannounced Rounds	1	1
Human Resources / Director of Personnel	1	1
Random Staff	12	12
Specialized Staff		
Intermediate or higher-level staff responsible for conducting and documenting unannounced rounds	1	1
Line Staff – same as random in this audit	1	Random Staff
Education staff – none at EDL	1	Random Staff
Program staff who work with youthful inmates – same as random at EDL	1	Random Staff
Medical Staff – none at EDL	1	Random Staff
Mental Health Staff	1	1
Non-medical staff involved in cross gender searches	1	Random Staff
Administrative (human resources) staff	1	1
Sexual Assault Forensic Examiner (SAFE) and Sexual Assault Nurse Examiner (SANE) staff	1	1

Volunteers and contractors who have contact with inmates	1	0
Investigative staff	1	N/A
Staff who perform screening for risk of victimization and abusiveness	1	1
Staff who supervise inmates in segregated housing	1	N/A
Staff on the sexual abuse incident team – same as Agency Head, Program Director,	1	N/A
Designated staff member charged with monitoring retaliation – same as Agency Head and Program Director / PREA Coordinator	1	2
First responders – All EDL staff serve as First Responders	1	Random Staff
Total Staff Interviews Completed		19

The staff interviews and a review of the staff training records revealed the staff were not appropriately trained in accordance with 115.315 (b) - Limits to cross-gender viewing and searches. The staff consistently explained the female staff did perform pat down searches on the outside of the residents clothing in situations that did not meet the definition of exigent circumstances. Everyday Life management was provided clarification on the standard and shown where all staff could complete the necessary on-line PREA training to meet the standard.

Resident Interviews:

EDL provided both auditor Howell and auditor Williams with private interview spaces in the administration building. Howell conducted interviews in a therapist office and Williams conducted interviews in a conference room. Both areas had closing doors and were out of view from other staff and residents.

Thirteen of the twenty-six residents present on site during the audit were interviewed. There were 26 residents on each day of the audit. The selection method used to select youth was every third name on Everyday Life August Client List provided by facility management. Auditors divided up the list of youth to be interviewed. Because there were no allegations during the audit period, there were no youth to interview who had reported an allegation or been involved in a PREA related incident. The resident files reviewed provided documentation that corroborated there were no residents present who met the targeted resident criteria. Intake and assessment staff suspected one youth identified as potential LGBTQ during intake assessments, but the resident denied identifying as LGBTQ during the PREA interview and also denied it with a therapist soon after being admitted to the facility.

Staff interview answers and a review of resident files (intake assessment and historical documents) corroborated that no residents present met any targeted resident interview criteria.

Resident interviews were conducted in compliance with the standards set forth in the PREA Compliance Instrument – Interview Guides for Residents. The breakdown of resident number and type of interviews conducted is below. The resident interviews were conducted in compliance with the standards set forth in the PREA Auditor Handbook.

Total population during on-site interviews 26	Total bed capacity 36
Overall minimum number of resident interviews 10	Number required 10
Minimum number of random resident interviews 5	Number interviewed 13
Minimum number of targeted resident interviews 5	Number interviewed 0 (there were no targeted residents at the facility.)
Breakdown of required targeted resident interviews	
Residents with a physical disability 1	Number interviewed 0 (none at the facility)
Residents who are blind, deaf, or hard of hearing 1	Number interviewed 0 (none at the facility)
Residents that are LEP 1	Number interviewed 0 (none at the facility)

Residents with a cognitive disability 1	Number interviewed 0 (none at the facility)
Residents that identify as lesbian, gay, or bisexual 1	Number interviewed 0 (none at the facility)
Residents that identify as Transgender or intersex 1	Number interviewed 0 (none at the facility)
Residents in isolation 1	Number interviewed 0 (none at the facility)
Residents who reported sexual abuse 1	Number interviewed 0 (none at the facility)
Residents who reported sexual victimization during risk screening 1	Number interviewed 0 (none at the facility)

13 of 13 (100%) youth interviewed acknowledged receiving PREA information upon intake, watching the "PREA Video," and seeing the posters and hot line numbers posted in various locations on the campus. The posters included addresses for confidential mail correspondence and the posters were located within view of the phones the residents use for phone calls. Poster locations included intake office, dining areas, administration lobby, cottage living room, and therapist offices. Each of the youth interviewed could explain the meaning of the zero-tolerance policy towards sexual harassment and abuse. Each youth explained ways to advocate for themselves and others in the case of sexual abuse and harassment.

13 of 13 (100%) residents interviewed said they believed they were safe and the staff at Everyday Life cared about their safety.

Staff Training Files Review:

Auditor Howell and auditor Williams conducted a review of staff training files. The files selected were the same names of the random staff interviewed. The review was conducted using the PREA Audit – Juvenile Facilities Documentation Review – Employee Files Records template. The review of staff training files demonstrated the staff had PREA training as part of the new employee training and refresher training at least annually. Documents demonstrated EDL had conducted refresher training two weeks prior to the on-site audit. The staff PREA training was from the NIC website**.** Despite receiving training related to the standard prohibiting cross gender pat down searches, during the staff interviews female staff admitted to conducting over the clothing pat down searches of male residents. This issue constitutes corrective action for which auditor Williams redirected Program Director Wilson to the applicable staff training web site. The necessary corrective action (all staff retrained, and proof sent to auditor Howell) was agreed upon at the exit conference on August 30, 2019.

Personnel Files Review:

Auditor Howell and auditor Williams conducted a review of staff files. The files selected were the same names as the random staff interviewed. The review was conducted using the PREA Audit – Juvenile Facilities Documentation Review – Employee Files Records template. Required documentation for staff files were reviewed for compliance from 2016 to 2019. Staff files were compliant with initial and five year requirements, for applicable staff. All 19 staff files had documentation of criminal background checks, mandated reporter training, initial and refresher PREA training. Staff files did not include documentation related to institutional reference questions. Auditors Howell and Williams were unable to find any staff that had been hired in the past three years that listed previous employment at a juvenile institution therefore EDL was not out of compliance. Auditor Howell provided a sample of a letter sent to previous employers that employed EDL applicants that included the applicable institutional reference questions. On August 30, 2019, EDL Personnel Director Eric Payton provided auditor Howell a reference letter with the appropriate institutional questions on EDL letterhead. When applicable, the use of the letter shared and discussed will keep EDL compliant with the PREA reference standards.

Investigative Files Review:

As a result of EDL staff reporting zero investigations in their interviews, outside regulatory and investigative agencies reporting zero investigations, residents reporting zero allegations or investigations, and auditors Howell and Williams finding no documents related to sexual abuse or sexual harassment investigations there were no investigative files to review.

Exit Briefing:

On Friday August 30, 2019 the facility census was 26 youth. The on-site phase of the audit was completed at 6955 Broach Road, Bryan Texas 77808. An exit briefing meeting was conducted at 9:00AM and was attended by the following people:

a. Cedric Payton, Executive Director
b. Lorenza Wilson, Program Director
c. Lawrence Howell, Lead PREA Auditor
d. Jerome Williams, PREA Auditor

Auditor Howell led the discussion about the preliminary results of the audit including:

- The three phases of the PREA audit
- The three forms of verification (triangulation) used to determine compliance
- Facility strengths
- Facility weaknesses (including corrective action)
- Barriers experienced during the audit (which were none)
- The next steps to complete the audit

Post Audit Phase:

The audit methodology used and activities in the post audit phase included:

1. Lead auditor Lawrence Howell triangulating the information (evidence) learned in interviews, documents reviewed, and observations from the first two phases of the audit. The sources of verification were determined through the use of the Auditor Compliance Tool for Juvenile Facilities.
2. Auditor Howell writing the EDL Interim PREA Audit Report including corrective actions.
3. Sending requested sections of the interim report to Teresa Stroud of the National PREA Resource Center for review.
4. Sending the Interim PREA Audit Report to EDL for corrective action on November 5, 2019
5. Following receiving proof of corrective action completion, the Final PREA Audit Report was issued on February 10, 2020.
6. In accordance with PREA standards, the facility was instructed to post this final report on the agency website within 90 days of receiving it.
7. This is the Final Report.

Facility Characteristics

The auditor's description of the audited facility should include details about the facility type, demographics and size of the inmate, resident or detainee population, numbers and type of staff positions, configuration and layout of the facility, numbers of housing units, description of housing units including any special housing units, a description of programs and services, including food service and recreation. The auditor should describe how these details are relevant to PREA implementation and compliance.

Everyday Life Residential Treatment Center (EDL) is located at 6955 Broach Road in Bryan Texas. EDL is a non-profit 501 © 3 organization governed by a Board of Directors and managed daily by an experienced on-site management team.

Established in 2001, the Everyday Life Inc. Residential Treatment Center is a 36 bed, all male youth aged 8 to 17), non-secure, medium security / staff secure level, Title IV (e) residential treatment center located in Bryan Texas. Over the past 12 months the facility population has averaged 32.92 residents. On each day of the on-site audit the facility population was 26 residents. At the time of the on-site audit, EDL had 32 total staff, 2 contractors (both therapists), and zero volunteers.

The facility operations are licensed by The Texas Department of Family and Protective Services located in Bryan, Texas. Bryan is located in the Brazos Valley. The facility is located on 68 acres approximately seven miles from the center of town in a very rural setting. There are six facility buildings, an outdoor paved basketball court, and extensive space for outdoor activities. Since the 2016 PREA audit, one building, a former dormitory used for storage, was demolished and removed. Also, since the last audit, the stormwater drainage canal system was improved. There were no other reported facility changes or improvement.

The facility has three living cottages comprised of a kitchen area for food service that includes home-like storage cabinets, pantry and appliances. The dining/day room includes a dining table and couches facing a television screen. Two cottages have 16 open bay bunk beds (eight on each side of the building) and one cottage has six beds. The 16 bed cottages each have a time out room where youth can spend a self-placed time out period. Each sleeping area includes separate, single user bathroom and shower rooms. All closets and utility rooms remain locked and only the staff have access keys. Each youth has their own locker to store personal items.

When female staff enter the building, they announce themselves since they are the opposite gender of the youth served. This was confirmed in the staff and student interviews. Youth only change their clothing, shower, and use the bathroom in private single person bathrooms. There is no opposite gender viewing during any of the above-mentioned activities. There are no surveillance cameras at Everyday Life Inc. Residential Treatment Center, however with the open campus setting and open bay style cottages the staff are able to provide appropriate supervision as there are few places that someone could hide (blind spots) from direct view of a staff member. Everyday Life is to be commended for the facility staff's consistency in locking doors. Storage cabinets, office doors, bathroom doors, shower room doors, and closets remained locked and a staff member was needed to gain access to any of the areas. Auditors Howell and Williams observed good supervision practices throughout the on-site phase of the audit. Staff positioning and constant walking around reduced the opportunity for residents to be unsupervised.

To ensure there is documentation that night staff stay awake there is a watchman's clock type system in place. Timecards are issued to the night staff. Every 15 minutes the staff are required to punch their timecard with a time clock that marks the day/time of the punch. Each morning the timecards are submitted to the supervisor so that the time periods between punches can be evaluated.

Youth attend schools nearby with education services provided by the Bryan Independent School District.

Housing, meals, recreation, supervision, and treatment services are provided by age appropriate multicultural staff that appeared to match well with the ethnic diversity of the youth being served. EDL Program Director Wilson reported the breakdown of the staff ethnic diversity and the ethnic diversity of the residents. See below:

Ethnicity	Staff %	Residents %
African American	50%	35%
Caucasian	35%	35%
Hispanic / Other	15%	30%

The mission of Everyday Life Residential Treatment Center is “to provide a safe, sanitary and nurturing environment to its residents. The residents are afforded the opportunity to reach self-awareness in a structured environment, which allows privileges as they relate to a systematic behavior program. To provide counseling and support necessary to strengthen families and unite children with their family of origin or a permanent family whenever possible.“ The program focuses on strong on-site staff to resident ratios for supervision and safety. Other services provided on site include social work, family reunification, and mental health services provided by licensed therapists. Off-site services include medical, vocational and educational services.

Summary of Audit Findings

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

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

Standards Exceeded

Number of Standards Exceeded: 0

List of Standards Exceeded: N/A

Standards Met

Number of Standards Met: 41

List of Standards Met: 311, 312, 313, 316, 317, 318, 321, 322, 331, 332, 333, 334, 335, 341, 342, 343, 351, 352, 353, 353, 354, 361, 362, 363, 364, 365, 366, 367, 368, 371, 372, 373, 376, 377, 378, 381, 382, 383, 386, 387, 388

Standards Not Met

Number of Standards Not Met: 3

List of Standards Not Met: 315 **,** 388, 389

115.315; The facility does not meet the requirements of standard 115.315 (a, b, c and f). Corrective Action: Everyday Life management was provided clarification on the standards related to cross gender pat down searches and the auditors explained how all staff could complete the necessary on-line training to meet the standard. Corrective action includes EDL management ensuring all direct care staff are retrained on cross gender strip searches and certificates of training completion for each staff are sent to auditor Lawrence

Howell. The maximum timeline to accomplish the corrective action and show proof is as 180 days from EDL receiving the Interim PREA Audit Report.

Corrective Action: Training was completed on October 15th and October 29th, 2019. Proof of corrective action was e-mailed to Lead Auditor Lawrence Howell. Evidence included the staff training session sign in sheets (with signatures) and the power point curriculum used.

115.388; The facility does not currently meet the requirements of standard 115.388 (c). "The agency's report shall be approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means." Corrective Action Required: The Director of Administration must post a memo on the agency web page, in place of an annual report that compares aggregated incident data. The memo shall serve as notice that EDL had zero allegations or investigations related to sexual abuse or harassment during the past 12 months. Proof of corrective action will be e-mail notification of the posting on the EDL web site and Auditor Lawrence Howell verifying the posting. The maximum timeline to accomplish the corrective action and show proof is 180 days from EDL receiving the Interim PREA Audit Report.

Corrective Action: On Sunday February 9, 2020 Lead Auditor Lawrence Howell confirmed the corrective action was completed on the EDL website. The facility web page states, "Everyday Life (DL) Had zero allegations or investigations related to sexual abuse or harassment during the past 12 months. (August 2018-2019). www.edlrtc.com

115.389 (b) The facility does not currently meet the requirements of standard 115.389 (b). "The agency shall make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means. Corrective Action Required: The Director of Administration must post a memo on the agency web page a memo that states in the place of an annual report that compares aggregated incident data. The memo shall serve as notice that EDL had zero allegations or investigations related to sexual abuse or harassment during the past 12 months. Proof of corrective action will be e-mail notification of the posting on the EDL web site and Auditor Lawrence Howell verifying the posting. The maximum timeline to accomplish the corrective action and show proof is 180 days from EDL receiving the Interim PREA Audit Report.

Corrective Action: On Sunday February 9, 2020 Lead Auditor Lawrence Howell confirmed the corrective action was completed on the EDL website. The facility web pages states, "Everyday Life had zero allegations or investigations related to sexual abuse or harassment during the past 12 months. (August 2018-2019)." www.edlrtc.com

PREVENTION PLANNING

Standard 115.311: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

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

115.311 (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

115.311 (b)

- Has the agency employed or designated an upper-level 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

115.311 (c)

- If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.) ☐ Yes ☐ No ☒ NA
- Does the PREA compliance manager have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards? (N/A if agency operates only one facility.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's

conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in the making the compliance decision:

1. Documents reviewed included:
   a. PAQ
   b. Everyday Life Zero Tolerance Policy
   c. Staff acknowledgement of receipt and understanding of PREA Standards signed by staff, contractors, and volunteers.
   d. Zero Tolerance posters including phone numbers to report allegations.

2. Interviews included:
   a. Random residents
   b. Random staff
   c. Supervisory staff
   d. Executive Director
   e. Program Director / PREA Coordinator
   f. Director of Personnel

3. Site Review / Observation:
   a. PREA / Sexual Abuse Postings
   b. Web page www.everydaylifertc.com

115.311 (a) The Everyday Life (EDL) has a zero-tolerance policy towards all forms of sexual abuse, and sexual harassment. The purpose of the policy states:

> "The purpose of this rule is to establish the Everyday Life's (EDL's) zero-tolerance policy for any form of sexual abuse, sexual harassment, or sexual activity involving youth in the agency's care. This rule also addresses EDL's obligations under federal Prison Rape Elimination Act (PREA) standards for preventing, detecting, and responding to sexual abuse and sexual harassment."

The EDL Zero Tolerance Policy is available to staff, residents, and members of the public as is posted on the agency web page www.everydaylifertc.com.

115.311 (b) The agency has a designated PREA Coordinator. His position is an upper level position that has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities. The agency Zero Tolerance Policy states, " EDL designates an upper-level staff member as the agency wide PREA Coordinator."

EDL designated Director Cedric Payton as the Agency PREA Coordinator. Program Director Lorenza Wilson is the designee in Mr. Payton's absence. Through interviews of both individuals, this auditor found that both upper level staff understood the PREA standards and how they are implemented at Everyday Life Residential Treatment Center. Mr. Payton and Mr. Wilson explained they had sufficient time and authority to coordinate the facilities efforts to comply with PREA standards.

115.311 (c) According to the PREA Compliance Coordinator and Manager, the agency operates only one facility, therefore this is considered N/A.

Through observation during the on-site audit, interviews of both residents and staff, and reviewing resident and staff files it is evident EDL includes the requirements of this provision in the facility daily operations. Upper level staff as well as direct care staff could explain the intent of PREA and how it is implemented at EDL.

The facility meets the requirements of standard 115.311.

Corrective Action Findings: None

Standard 115.312: Contracting with other entities for the confinement of residents

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

115.312 (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 adopt and 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

115.312 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:

1. Documents reviewed included:
   a. PAQ
   b. Everyday Life Zero Tolerance Policy
   c. Resident files

2. Interviews included
   a. Director of Administration / PREA Coordinator
   b. Program Director / PREA Manager
   c. Director of Personnel
   d. Random Staff

3. Site Review / Observation:
   a. N/A

115.312 (a) Everyday Life Residential Treatment Center is not a public agency. EDL is a non-profit private agency run facility. The EDL PAQ states the agency has not entered into or renewed a contract for the confinement of their residents. The agency Chief Executive Officer Cedric Payton and EDL Program Director confirmed in their interviews that the agency does not contract for the confinement of their residents.

115.312 (b) Because EDL does not contract with outside agencies for the confinement of their residents, this standard is not applicable. The PAQ states that EDL is not required to monitor outside contracts for the placement of their residents because there are none. This was confirmed in the interview of the Director of Administration has the duty of agency contract administrator.

A review of the resident files showed no EDL resident placed in an outside contracted confinement facility.

As a result of the above information reviewed, on site observation, and information learned in the interviews this standard is not applicable.

Corrective Action Findings: None

Standard 115.313: Supervision and monitoring

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

115.313 (a)

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

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Generally accepted juvenile detention and correctional/secure residential practices? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any judicial findings of inadequacy? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any findings of inadequacy from Federal investigative agencies? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any findings of inadequacy from internal or external oversight bodies? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)? ☒ Yes ☐ No

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

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The number and placement of supervisory staff? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Institution programs occurring on a particular shift? ☐ Yes ☒ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any applicable State or local laws, regulations, or standards? ☒ Yes ☐ No

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

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

115.313 (b)

- Does the agency comply with the staffing plan except during limited and discrete exigent circumstances? ☒ Yes ☐ No

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

115.313 (c)

- Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.)
  ☒ Yes ☐ No ☐ NA

- Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.) ☒ Yes ☐ No ☐ NA

- Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.) ☐ Yes ☐ No ☒ NA

- Does the facility ensure only security staff are included when calculating these ratios? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.) ☐ Yes ☐ No ☒ NA

- Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph? ☒ Yes ☐ No

115.313 (d)

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

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The facility’s deployment of video monitoring systems and other monitoring technologies? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan? ☒ Yes ☐ No

115.313 (e)

- Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

- Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

- Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? (N/A for non-secure facilities) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:

1. Documents reviewed included:
   a. PAQ
   b. EDL Zero Tolerance Policy
   c. EDL Staffing Plan
   d. EDL Unannounced Rounds Logs
   e. EDL Facility Schematics
   f. EDL Staff Roster
   g. EDL Resident Roster

2. Interviews included
   a. Random residents
   b. Random staff
   c. Director of Administration / PREA Coordinator
   d. Program Director / PREA Compliance Manager
   e. Director of Personnel
   f. Random Staff

3. Site Review / Observation:
   b. Staff to student ratio observations at multiple times per day

115.313 (a) EDL's Zero Tolerance Policy states that EDL develops and implements a written staffing paln to provide adequate levels of staffing or video monitoring (if applicable) to protect youth against sexual abuse. (page 3, (3), (A), (i)) The PAQ showed no instances of a deviation from the planned staff to student ratio. Through the staff interviews, the auditors found no reports of short staffing or ratio issues in the daily

operations. 13 of 13 residents reported feeling safe at EDL and that staff provide adequate supervision of the residents. The agency staffing plan was reviewed by auditors Howell and Williams. When reviewing the staff rosters and comparing them to the average student population by month for the past 12 months (32.92) and taking into consideration a very low staff turnover rate (2 in the past 12 months), this auditor found no obvious reason to believe there had been a deviation from the facility staffing plan. EDL does not use surveillance cameras at all therefore they are not considered as part of the supervision of residents and staffing plan. Evidence of compliance with this standard was gathered in interviews of the Director of Administration and Program Director. Both individuals confirmed the EDL staffing plan is developed to protect residents, video monitoring is not part of the plan, and the staffing plan is reviewed weekly by the management team. In addition to the Director of Administration and Program Director, the Director of Personnel personally observes the staff to student ratios and takes into consideration the current composition of residents to ensure compliance with the plan.

115.313 (b) The EDL Zero Tolerance Policy requires constant supervision and monitoring of the residents while in the facility. The policy states that the facility maintains staff ratios at all times unless imminent and dangerous circumstances take place that alter the ratio. The established ratios are 1:5 during waking hours and 1:15 during sleeping hours. On-site observations by this auditor, during the audit, exceeded the established written ratios. Observed ratios were 1:4, 1:3, 1:2, and 1:1.

115.313 (c) The facility roster showed 22 full time staff employed for a current resident population of 26 residents. Observed staff to student ratios were 1:4, 1:3,1:2 and 1:1. Auditors found no evidence nor was there a report of the staff to student ratio deviating from the planed ratio of 1:5 daytime and 1:15 nighttime ratio. During the facility tour/review, when asked, “How often do you see staff? 2 of 2 residents replied that direct care staff were present at all times while the youth were on campus.

115.313 (d) When interviewed, the Executive Director, Director of Personnel, and Program Director each replied the staffing plan is reviewed and revised at least annually and when necessary.

115.313. (e) The auditors did find evidence to support the PAQ that stated higher level supervisors conducted unannounced rounds on all shifts. The facility’s Zero Tolerance Policy states that disciplinary action will occur if staff alert other staff of the unannounced rounds. During random staff interviews, the staff explained the unannounced rounds do occur. Frequency was reported as once per shift. Facility management provided unannounced rounds logs to demonstrate compliance. This is an improvement since the 2016 PREA Audit where the logs were not present.

During the random staff and resident interviews, the interviewees reported the method of opposite gender staff announcing their presence on the cottage upon arrival. During auditor visits to the cottages, private restroom time was observed where opposite gender staff could not see residents because the bathrooms are single use with locking doors. The shower rooms are designed the same way to prohibit opposite gender staff from seeing residents in the shower rooms. EDL employs many female staff at the all-male resident facility. The physical plant design and operational practices allow privacy in bathroom use, changing clothes, and showering, therefore demonstrating compliance with this PREA standard.

Based on the auditor observations, information shared during the staff and resident interviews, and the documents reviewed during the Pre On-Site, On-Site, and Post On-Site phases of the audit, the facility meets the requirements of standard 115.313

Corrective Action Findings: None

Standard 115.315: Limits to cross-gender viewing and searches

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

115.315 (a)

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

115.315 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances? ☐ Yes ☒ No ☐ NA

115.315 (c)

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

- Does the facility document all cross-gender pat-down searches? ☐ Yes ☒ No

115.315 (d)

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

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

- Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit? ☒ Yes ☐ No

- In facilities (such as group homes) that do not contain discrete housing units, 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? (N/A for facilities with discrete housing units) ☒ Yes ☐ No ☐ NA

115.315 (e)

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

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

115.315 (f)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:
a. PAQ
b. Everyday Life Zero Tolerance Policy
c. Staff training files
d. Search logs

Interviews included:
a. Random residents
b. Random staff
c. Supervisor staff
d. Security staff

Site Review / Observation:

a. Cottages
b. Administrative areas

115.315 (a-c): The staff interviews and a review of the staff training records revealed the staff were not appropriately trained or conducting pat down searches in accordance with 115.315 (a, b, and c) Limits to cross-gender viewing and searches. The staff explained the female staff actually do pat down searches on the outside of the residents clothing in situations other than exigent circumstances. Specifically, female staff explained they sometimes complete pat down searches after youth return from the community. Most staff explained the male staff do most, but not all, of the pat down searches. The specific number of pat down searches was not documented. The EDL PAQ states the facility does not conduct cross gender strip or cross gender visual body cavity searches of residents.

115.315 (d): EDL has policies that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances. The facility is designed to prohibit cross gender viewing of youth performing such personal actions. Bathrooms and showers are single use and have locking doors to avoid staff or peers from viewing residents in either location. The facility schematic shows the single resident shower/bathrooms and the areas were observed by the PREA auditors during the tour and facility review.

EDL requires staff of the opposite gender to announce their presence when entering a resident cottage. Auditors observed female staff announcing their presence when the entered Cottages 1 and 3. In interviews female staff gave examples of how they announce themselves. Answers included; “Hello gentlemen Ms. (name) is back in the cottage” and “Female staff on the cottage.” In resident interviews 12 of 12 residents confirmed hearing opposite gender staff announcing themselves when the entered the cottage.

115.315(e) Per the EDL Zero Tolerance Policy and confirmed by the auditors during the intake staff interviews, EDL always refrains from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident’s genital status. If a resident’s genital status is unknown, the intake staff review the resident’s personal history and medical documents and may determine genital status during conversations with the resident, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner.

115.315(f) EDL did not show proof of properly training security staff on 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. During interviews staff and residents were able to consistently demonstrate a pat down procedure that included running the back of a staff’s hand on the outside of a residents clothing to determine if there was any contraband hidden under the clothing.

As a result of not initially meeting the requirements listed in 115.315 (a, b, c and f) the facility completed the corrective action before the Final Report was written. See below.

Corrective Action: 115.315 (a, b, c and f) - Everyday Life management was provided clarification on the standards related to cross gender pat down searches and the auditors explained how all staff could complete the necessary training to meet the standard. Corrective action includes EDL management ensuring all direct care staff are retrained on cross gender strip searches and certificates of training completion for each staff are sent to auditor Lawrence Howell. The maximum timeline to accomplish the corrective action and show proof was established as 180 days.

Corrective Action: Training was completed on October 15th and October 29th, 2019. Proof of corrective action was e-mailed to Lead Auditor Lawrence Howell. The proof included the staff training session sign in sheets (with signatures) and the power point curriculum used.

Standard 115.316: Residents with disabilities and residents who are limited English proficient

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

115.316 (a)

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.) ☒ Yes ☐ No

- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision? ☒ Yes ☐ No

115.316 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient? ☒ Yes ☐ No

- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

115.316 (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 §115.364, or the investigation of the resident's allegations? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PAQ
b. Everyday Life Zero Tolerance Policy
c. Intake and Orientation Documentation
d. Resident Orientation Handbook (English and Spanish)
e. PREA Posters
f. Bryan Independent School District Agreement

Interviews included:

a. Random residents
b. Random staff
c. Supervisory staff
d. Security staff

Site Review / Observation:

a. Cottage postings
b. Administrative Building postings

115.316 (a) The EDL Zero Tolerance Policy states that EDL takes appropriate steps to ensure that youth 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. Such steps include providing access to:

(i) Interpreters, and
(ii) written materials provided in formats or through methods that ensure effective communication.

Since the 2016 PREA audit EDL had the Resident handbook translated into Spanish. This is especially important because during the audit the Hispanic population of EDL was 30% of the total population.

115.316. (b) When interviewed facility managers explained they do whatever is necessary to ensure the residents understand the PREA standards and their rights. They made it clear when necessary they use staff as translators and when appropriate Bryan Independent School District interpreting resources for residents who may be deaf, speech impaired, limited in English proficiency, blind and or low vision or who are psychiatric or intellectually impaired. During the past 12 months, the facility did not have any youth who were assessed as needing interpreting services because they had a disability or were limited English proficient. This determination was made based on interviews of staff, administrators, and a review of the residents' case files.

115.316 (c) The PREA Coordinator and Intake staff explained EDL does not use resident interpreters or assistants for reporting sexual abuse and sexual harassment allegations as the practice could compromise the integrity of the reporting process. The facility's intake staff did have written PREA related information to provide to youth upon admission to EDL. At the time of the audit there were no residents listed or reported as needing interpreter services or the need for translated PREA related documents.

The staff and resident interviews resulted in consistent responses that EDL had not had a recent need for the use of interpreters or services for residents with a disability that hindered their ability to communicate an allegation related to sexual abuse or harassment.

The facility meets the requirements of standard 115.316.

Corrective Action: None

Standard 115.317: Hiring and promotion decisions

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

115.317 (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

115.317 (b)

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

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

115.317 (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 consult any child abuse registry maintained by the State or locality in which the employee would work? ☒ 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

115.317 (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

- Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

115.317 (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

115.317 (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

115.317 (g)

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

115.317 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PAQ
b. Everyday Life Zero Tolerance Policy
c. General Residential Operating Manual
d. Criminal Records and Child Abuse Registry Check Documentation
e. Employment Application
f. Self-Disclosure Affidavit
g. Training Records
h. Resident Orientation Handbook (English and Spanish)
i. PREA Posters
j. Bryan Independent School District Agreement

Interviews included:

a. Program Director / PREA Coordinator
b. Director of Personnel
c. Chief Executive Officer

Site Review / Observation:

a. None to observe.

115.317 (a) The EDL Zero Tolerance Policy states EDL does not hire or promote anyone who may have contact with youth and does not use services of any contractor who may have contact with the person if the person:

(i) has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution; or

(ii) has been convicted or civilly or administratively adjudicated or 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.

Personnel Director Eric Payton confirmed in his interview that EDL has not hired, promoted, or contracted with anyone who meets the criteria listed above in (i) and (ii). A review of personnel files revealed no documented evidence that would show EDL was out of compliance with this section of standard 115.317.

115.317 (b) Section (6) (B) of the EDL Zero Tolerance Policy states that for any person who may have contact with juveniles, EDL considers any incidents of sexual harassment in determining whether to hire, promote, or contract for services. Director of Personnel stated in his interview that EDL would find out such information through criminal background checks, pre-employment reference checks, and a thorough interview of the applicant for the open position. A review of personnel files revealed no documented evidence that would show EDL was out of compliance with this section of standard 115.317.

115.317 (c) Before hiring new employees who may have contact with youth, the EDL Zero Tolerance Policy requires EDL hiring staff:

(i) Performs a criminal background records check
(ii) Consults the child abuse registry maintained by Texas Department of Family and Protective Services (DFPS); and
(iii) 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.

EDL has been conducting background checks, child abuse registry checks, and completing reference checks, however EDL did not have documented proof of attempts to ask previous employers of applicant's past involvement in PREA related incidents. During the on-site audit, auditors shared examples of letters to send and proof of phone screens conducted with prior institutional employers for information on any history of applicants involved in PREA related incidents. The EDL Director of Personnel, Eric Payton, immediately adopted a letter format, suggested by auditor Lawrence Howell, for use the next time EDL gets an applicant with institutional experience. On Friday August 30, 2019 Mr. Payton provided auditors with a copy of the new EDL institutional reference check letter to be used in the future.

115.317 (d) Per the EDL Zero Tolerance Policy (page 4, section 6), before enlisting the services of a contractor who may have contact with youth, EDL:

(i) Performs a criminal background records check
(ii) Consults the DFPS child abuse registry

A review of the two existing contractor files revealed no documented evidence that would take EDL out of compliance with this section of standard 115.317.

115.317 (e) EDL conducts criminal background checks of current employees and contractors who may have contact with residents every five years. This was evidenced through audits of the staff and contractor files and confirmed in interviews with the Executive Director and Director of Personnel. Compliance in this area was also much improved since the 2016 audit.

115.317 (f) EDL did provide written evidence about asking all applicants and employees who may have contact with residents directly about previous PREA related misconduct described in paragraph 115.317 (a). Director Eric Payton disclosed in his interview that the facility also practices a policy of ongoing self-disclosure regarding involvement in PREA related incidents.

115.317 (g) In accordance with this standard, EDL Director of Personnel and the Program Director stated in their interviews that material omissions regarding such misconduct (PREA related) or the provision of materially false information is grounds for termination of employment. This statement is documented on page 5 section 6 (F) of the EDL Zero Tolerance Policy.

115.317 (h) EDL policy does state that unless prohibited by law, EDL provides information on substantiated allegations of sexual abuse or sexual harassment involving former employees upon receiving a request from an institutional employer for whom the former employee has applied to work. In his interview, EDL Director of Personnel explained that such disclosure would not be an issue because most reference checks are accompanied by written permission to disclose information from the subject of the reference check. At the time of the audit, EDL Director of Personnel said they had not received such a request for information from a juvenile institution.

In addition, the Director of Personnel and Program Director / PREA Coordinator affirmed separately in their interviews that EDL does consider all items listed in 115.317(a-h) when making hiring and promotion decisions.

Based on the information received in the interviews (of the Executive Director, Program Director, and Director of Personnel), the staff files reviews showing compliance, and the fact the institutional reference check letter was written and ready for use before the end of the on-site audit, the facility meets the requirements of standard 115.317.

Corrective Action: None

Standard 115.318: Upgrades to facilities and technologies

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

115.318 (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

115.318 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:
a. PAQ
b. Facility Schematics

Interviews included:

a. Program Director
b. Director of Personnel
c. Executive Director

Site Review / Observation:
a. Observation of the campus, including the location of the cottage (used for storage) that was removed.

115.318 (a) The Executive Director, Program Director, and Director of Personnel all confirmed in their interviews that there have not been any expansion or modification of existing facilities to consider the effect of the design, acquisition, expansion, or modification upon EDL's ability to protect residents from sexual abuse. One building was demolished and removed since the 2016 audit. The building was not replaced. During the facility tours auditors were shown the location of the one building (cottage used for storage) that had been removed since the 2016 audit.

115.318 (b) EDL has no cameras or video surveillance system. Site managers are aware that if/when EDL does install such systems they need to first consider how it will be used to protect the residents in the facility. The auditors recommended the installation of cameras to enhance, not replace, resident supervision and to be used as a tool to review “what happened” in the event of a PREA incident.

The interviews of upper management, the tours of the facility, and schematics provided to the auditors all corroborated that the facility meets the requirements of standard 115.318.

Corrective Action Findings: None

RESPONSIVE PLANNING

Standard 115.321: Evidence protocol and forensic medical examinations

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

115.321 (a)

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

115.321 (b)

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☐ Yes ☐ No ☒ NA

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

115.321 (c)

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate? ☒ Yes ☐ No

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

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

- Has the agency documented its efforts to provide SAFEs or SANEs? ☒ Yes ☐ No

115.321 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? ☒ Yes ☐ No

- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? (N/A if the agency *always* makes a victim advocate from a rape crisis center available to victims.) ☐ Yes ☐ No ☒ NA

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

115.321 (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

115.321 (f)

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

115.321 (g)

- Auditor is not required to audit this provision.

115.321 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PAQ
b. Everyday Life Zero Tolerance Policy
c. Memorandum from Brazos County Sheriff Department
d. Scotty's House Brazos Valley Child Advocacy Center and Sexual Assault Recovery Center documentation.

Interviews included:

a. Program Director / PREA Manager
b. Director of Personnel
c. Director of Administration
d. SAFE/SANE Nurse at Baylor Scott & White Medical Center
e. SARC (Sexual Assault Resource Center - 24 hour hotline and services)
f. Random staff interviews
g. Random resident interviews

Site Review / Observation:

a. Facility postings
b. Brochures available to residents

115.321 (a) Section (f) Responsive Planning (1) (A) of the EDL Zero Tolerance Policy, EDL does follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions when responding to allegations of sexual abuse.

115.321 (b) The CEO and Program Director both stated that the Department of Family and Protective Services (DFPS) and the Brazos County Sheriff Department follow a protocol that is developmentally appropriate for youth and is adapted from the most recent edition of the US Department of Justice's Office on Violence Against Women publications. Auditors did receive a copy of a Memorandum of Agreement between EDL and Brazos County Sheriff Christopher Kirk and spoke with the SAFE/SANE nurse Niki Johnson at Baylor Scott & White Medical Center to confirm the latest approved protocols are being implemented. Auditors were able to ascertain and confirm the following:

- DFPS is responsible for administrative investigations
- Brazos County Sheriff's Department is responsible for criminal investigations of sexual abuse
- Baylor Scott & White is the hospital responsible for conducting SANE sexual abuse investigations
- Scotty's House and the Sexual Assault Resource Center are responsible for providing outside the facility emotional support and crisis counseling services

115.321 (c) In event of a PREA related allegation, EDL calls the Sheriff for criminal investigation and the Sheriff's Department representative would take the resident to Baylor Scott and White hospital for the SANE examination. Baylor Scott and White hospital services include Sexual Assault and Violence Response and Child Protection Teams. Nurse Johnson referred auditor Howell to the hospital web site where under the "Forensic Medicine" tab the following mission statement was found: "The Sexual Assault and Violence Response Team and Child Protection Team at Baylor Scott and White provide compassionate, sensitive, timely care for victims of violent crimes, child abuse and neglect."

Forensic Nurse Niki Johnson explained she was the lead forensic nurse, but in her absence another forensic nurse would be on duty. She explained it was hospital practice to have a forensic nurse available 24 hours a day. The hospital web site explains, "when sexual assault has occurred, a forensic nurse who is a sexual assault nurse examiner (SANE) will provide nonjudgmental, compassionate care to the patient. SANEs are registered nurses who have had specialized training in the comprehensive medical forensic care of patients who have experienced sexual assault. They are certified by the Texas Office of the Attorney General."

115.321 (d) Rape Crises Center services are provided free of charge by Scotty's House Brazos Valley Child Advocacy Center and the Sexual Assault Resource Center (SARC) community-based organizations that provide emotional support, counseling and advocacy services. Neither organization are part of the criminal justice system. Of the residents interviewed, all were able to describe how to access the services in a confidential manner. The Baylor Scott & White web site lists referral to an advocate from a local advocacy organization who dan provide information about services including counseling.

115.321 (e) The EDL PREA Coordinator explained that EDL does have a qualified mental health counselor on duty most days to provide advocacy and emotional support services. However, the Scotty's House and SARC services remain available 24/7 to support victims through the forensic medical examination process and investigatory interview process. Services include emotional support, crises intervention, information, and referrals.

115.321 (f) EDL provided auditors a Memorandum of Agreement between EDL and Brazos County Sheriff (dated 08/24/19) confirming the Sheriff's department conducts all criminal investigations. A phone interview with the SANE Nurse at Baylor Scott & White hospital confirmed she is qualified to conduct Sexual Assault Medical Forensic Examinations for obtaining usable evidence for administrative or criminal investigations.

1155.321 (g) Auditor is not required to audit this provision.

115.321. (h) N/A because EDL *always* makes a victim advocate from a rape crisis center available to victims.

The facility meets the requirements of standard of 115.321.

Corrective Action Findings: None

Standard 115.322: Policies to ensure referrals of allegations for investigations

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

115.322 (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

115.322 (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

115.322 (c)

- If a separate entity is responsible for conducting criminal investigations, does the policy describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for criminal investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

115.322 (d)

- Auditor is not required to audit this provision.

115.322 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PAQ
b. Everyday Life Zero Tolerance Policy
c. Memorandum from Brazos County Sheriff Department
d. Scotty's House Brazos Valley Child Advocacy Center and Sexual Assault Recovery Center documentation.
e. Staff Training Files

Interviews included:

a. Program Director / PREA Manager
b. Director of Administration / PREA Coordinator
c. SAFE/SANE Nurse at Baylor Scott & White Medical Center
d. SARC (Sexual Assault Resource Center - 24-hour hotline and services)
e. Random staff interviews
f. Random resident interviews

Site Review / Observation:

c. Facility postings
d. Brochures available to residents
e. Facility web site: www.everydaylifertc.com

115.322 (a) The Everyday Life Residential Treatment Center (EDL) Zero Tolerance Policy requires that all allegations of sexual abuse and sexual harassment are investigated by the Everyday Life PREA Compliance Team and are reported to the Texas Department of Family and Protective Services (TDFPS) for administrative investigations and the Brazos County Office of the Sheriff for criminal investigations. During interviews, Jim Steward (Deputy Chief Brazos County Sherrif's Office) and Dana (Agent #5005 of TDFPS) confirmed there were zero reported allegations of allegations or investigations during the past 12 months, therefore there were zero EDL administrative investigations and zero criminal investigations. As result of zero investigations, the auditors could not review investigation reports to confirm the documentation matched the written procedure or PREA standards. Interviews of staff confirmed the staff's knowledge of which agencies are responsible for administrative and criminal investigations in all allegations of sexual abuse and sexual harassment.

115.322 (b) Since the 2016 PREA on-site audit, the EDL Zero Tolerance Policy was finalized and posted in the agency web page. The Zero Tolerance Policy is 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. There were zero referrals in the past 12 months as evidenced by auditor conformation with the Department of Family and Protective Services, Brazos County Sheriff's Department, interviews with EDL managers, and interviews of random staff and students.. As a result of there being no evidence showing allegations during the past 12 months, this auditor asked the Program Director and CEO if there had been any allegations since the last PREA audit. Both the EDL staff responded "no" there had not been any. This auditor also reviewed the previous (2016) Final PREA Audit Report for any reported allegations or investigations. The 2016 audit report listed none. A review of the EDL website did show the agencies Zero Tolerance Policy that did include the policy that all allegations of sexual abuse or sexual harassment are referred to the Brazos County Sheriff's Office and TDFPS as they have the legal authority to conduct criminal investigations.

115.322 (c) The EDL Zero Tolerance Policy, section (2) (A-B) states that the EDL PREA Compliance Team reviews all allegations of sexual abuse and sexual harassment reports will report all allegations to the Texas Department of Family and Protective Services (TDFPS) and the Brazos County Office of the Sheriff for administrative and criminal investigations. TDFPS and Brazos County Sheriff's Department are the authorized outside agencies who conduct investigations into EDL allegations of sexual abuse and sexual harassment.

115.322 (d) The auditor is not required to audit this provision.

115.322 (e) Auditor is not required to audit this provision.

During staff interviews, including the Program Director / PREA Coordinator, Chief Executive Officer, and random staff, it was evident that the facility staff understood the investigation process and were able to explain the process for administrative and criminal investigations. The staff training records showed the staff received appropriate and current PREA training related to policies to ensure referrals of allegations for investigations.

The facility does meet all of the requirements of standard 115.322 (a-e)

Corrective Action Findings: None

TRAINING AND EDUCATION

Standard 115.331: Employee training

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

115.331 (a)

- Does the agency train all employees who may have contact with residents on its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on residents' right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on the right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on the dynamics of sexual abuse and sexual harassment in juvenile facilities? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on the common reactions of juvenile victims of sexual abuse and sexual harassment? ☒ 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 and how to distinguish between consensual sexual contact and sexual abuse between residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to avoid inappropriate relationships with residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on relevant laws regarding the applicable age of consent? ☒ Yes ☐ No

115.331 (b)

- Is such training tailored to the unique needs and attributes of residents of juvenile facilities? ☒ Yes ☐ No

- 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

115.331 (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

115.331 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PAQ
b. Everyday Life Zero Tolerance Policy
c. Training Documentation (rosters and certificates)
d. Volunteer and Contractor's PREA related training

Interviews included:

a. Program Director / PREA Coordinator
b. Random Staff
c. Specialized staff (EDL PREA Compliance Team members)
d. Contractors

Site Review / Observations:

a. None

115.331 (a) The EDL Zero Tolerance Policy does require that the facility provide PREA related training to all its employees who may have contact with youth. The EDL training includes the following:

- How to fulfill their PREA responsibilities under EDL policies and procedures
- Residents right to be free from sexual abuse and sexual harassment
- The right of residents and employees to be free from sexual abuse and harassment
- The right of residents to be free from retaliation for reporting sexual abuse and harassment
- The dynamics of sexual abuse and sexual harassment in juvenile facilities
- The common reactions of juvenile victims of sexual abuse and harassment
- How to detect and respond to signs of threatened and actual sexual abuse
- How to avoid inappropriate relationships with residents
- How to communicate effectively and professionally with residents including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents
- How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities
- Relevant laws regarding the applicable age of consent

115.331 (b) The EDL PAQ states training is tailored to the unique needs and attributes an gender of the residents at the facility. EDL is a single gender facility. The staff of the opposite gender receive the same training regardless of what cottage they are assigned. Training documentation received by the auditors supports this standard. The training is initiated during new employee orientation and is continued through annual refresher training.

115.331 (c) The EDL Zero Tolerance Policy states that EDL documents employees written verification that they receive PREA training and understand their PREA responsibilities. The agency provides refresher training on an annual basis. This was confirmed by auditing the employee training files.

115.331 (d) The EDL PREA Coordinator provided the auditors with training documentation showing as proof the staff acknowledge with their signature that they understand the training they received.

In the interviews, the staff demonstrated they had a good understanding of 115.331 (a, 1-11) and 115.331 (b), and 115.331 (c). Furthermore, the training documentation verified the completion of and understanding of the prescribed PREA training.

The facility meets the requirements of standard 115.331.

Corrective Action Findings: None

Standard 115.332: Volunteer and contractor training

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

115.332 (a)

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

115.332 (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

115.332 (c)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PAQ
b. Everyday Life Zero Tolerance Policy
c. Training Documentation (rosters and certificates)
d. Volunteer and Contractor's PREA related training

Interviews included:

a. Program Director / PREA Manager
b. Random Staff
c. Specialized staff
d. Contractors

Site Review / Observations:

a. None

115.332 (a) The EDL Zero Tolerance Policy states that EDL ensures and documents all volunteers and contractors who have direct access to youth have been trained on and understand their responsibilities under PREA and any other EDL policies and procedures and will implement the training skills provided while employed with EDL.

115.332 (b) The EDL Program Director / PREA Coordinator provided documentation of contractor's acknowledgement of their PREA responsibilities and training necessary for compliance with this provision.

115.332 (c) EDL does maintain documentation confirming that volunteers and contractors understand the training they have received. Auditors received copies of such documentation for two contractors who provide assessment and therapeutic services.

Auditors were able to interview two contractors and review their training documentation to determine EDL's compliance with 115.332 (a-c).

The facility meets the requirements of standard 115.332.

Corrective Action Findings: None

Standard 115.333: Resident education

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

115.333 (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
- Is this information presented in an age-appropriate fashion? ☒ Yes ☐ No

115.333 (b)

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents? ☒ Yes ☐ No

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

115.333 (c)

- Have all residents received the comprehensive education referenced in 115.333(b)?
  ☒ Yes ☐ No

- Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility?
  ☒ Yes ☐ No

115.333 (d)

- 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

115.333 (e)

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

115.333 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PAQ
b. Everyday Life Zero Tolerance Policy
c. Posters
d. Resident Handbook
e. PREA Brochure

Interviews included:

a. Program Director / PREA Manager
b. Intake Staff
c. Specialized Staff (Therapist)
d. Random Staff
e. Random Residents

Site Review / Observations:

a. Posters hanging in areas commonly used by residents such as:
    i. Cottages
    ii. Dining areas
    iii. Administration Building Hallways
    iv. Intake areas
    v. Counseling / Therapist offices
b. PREA brochures available to residents and staff.

115.333 (a) The Everyday Life residential treatment center Zero Tolerance Policy states that during the admissions/intake process the youth are provided, by EDL, age appropriate PREA information about the agencies Zero Tolerance Policy and how to report incidents or suspicions of sexual abuse, sexual harassment or sexual activity. This is done through verbal explanation by the intake staff and being provided the appropriate PREA education information in the PREA brochure and included in the Resident Handbook. The EDL management staff provided the auditors with the EDL Resident Handbook in English and Spanish. This is an improvement from the 2016 PREA audit.

When interviewed 13 of 13 residents reported learning of and understanding the zero-tolerance policy and how to report sexual abuse/sexual harassment. Over the past twelve months 96 residents were admitted to EDL. The intake packets include an acknowledgement signed by each resident that they received and understood the zero-tolerance policy information. When reviewing resident files, auditors found no evidence that there were residents who did not receive the required Zero Tolerance Policy information.

115.333 (b) The EDL Zero Tolerance Policy (3) (b) states that within 10 days after admission, EDL provides comprehensive, age appropriate education to youth about their rights to be free from sexual abuse, sexual harassment, and retaliation for reporting. Through the random resident interviews, the auditors found evidence that 13 of 13 residents had viewed the Safeguarding Your Sexual Safety PREA Video. Auditors were provided a copy of the video. Some residents reported viewing the video multiple times. 13 of 13 residents reported viewing video upon intake and soon after. 13 of 13 residents could not state how many days it was before they viewed the video again. When asked how long it was between video viewing responses included;

- “I don’t remember exactly…a few days”
- “a week or two”
- “I don’t know, but I have watched it so much I probably know it by heart”

All residents interviewed reported viewing the video in the past seven days. Auditors received a copy of the video as proof of the actual PREA education provided to residents.

During the intake staff interviews the auditors asked how they ensured current residents as well as those transferred from other facilities were educated on the agency’s Zero Tolerance Policy. Both intake staff confirmed that regardless of how, when, or where they came from all residents are provided the same resident education about their rights to be free from sexual abuse, sexual harassment, and retaliation for reporting.

When asked, “How long from the date of intake are residents made aware of their rights as prescribed by PREA?”, the staff replied:

- “Intakes are scheduled on days and at times when the intake staff are available to complete the intake assessment process.”
- Residents receive the PREA educational materials on the same day they arrive at EDL.”

Auditors reviewed the intake paperwork and the EDL Zero Tolerance Policy and confirmed the materials and information provided to the residents include the residents rights to be free from sexual abuse, sexual harassment, and retaliation for reporting such incidents.

115.333 (c) 13 of 13 residents interviewed responded “yes” when asked if they received PREA educational materials in accordance with 115.333 (a-f). 13 of 13 residents responded “yes” when asked if they were told about:

a. Your right to not be sexually abused or sexually harassed?
b. How to report sexual abuse or sexual harassment.
c. You right to not be punished for reporting sexual abuse or sexual harassment?

When asked, “how long after coming to EDL did you get the information (listed in a, b, and c above)?” 13 of 13 responded the same day they arrived.

The resident files showed resident acknowledgement of receiving and understanding the PREA education materials. There was not a space for the residents to acknowledge receiving a reeducation of the PREA information within 10 days of intake. Adding this section to the resident files was recommended by Auditor Howell to show documented proof the process was taking place in a timely manner. EDL provided this auditor a copy of the PREA brochure in the lobby of the administration building where residents commonly gather. It was recommended to the EDL Program Director / PREA Coordinator to provided copies of the PREA brochure in the resident cottages also.

115.333 (d) The Everyday Life (EDL) intake staff provided the auditors with the resident education in formats accessible to all residents at the facility during the audit. Materials also included those translated into Spanish. Auditors were able to review a documented MOU Agreement between EDL and Bryan Independent School District (BISD). BISD provides translation services and has the ability to provide PERA education materials in formats accessible for residents that are deaf, visually impaired, have limited reading skills or otherwise disabled. When intake staff were asked how intakes with limited reading skills could learn the PREA related information they responded the staff would read the print information to the resident with the limited reading skills, have the resident the youth watch the video, and show the resident how they can call the 1 800 hotline number to file a report or request emotional support services.

115.333 (e) The EDL Program Director / PREA Coordinator was able to clearly explain the resident PREA education process. Upon auditor review, 13 of 13 resident files reviewed included documentation including the residents written acknowledgement of receiving and understanding the PREA information. In the resident interviews the youth were able to explain the process consistent with what is written in the Zero Tolerance Policy and what is expected to meet this standard.

115.333 (f) During multiple tours of the Everyday Life facility, the auditors viewed PREA posters in the resident cottages. Posters included the name, address, and phone number to report sexual abuse and sexual harassment. Auditors also received a copy of and reviewed the PREA information in the resident handbook. Page 4 and 5 of the handbook includes the phone numbers that residents are encouraged to call in the event of an allegation of sexual abuse or harassment.

PREA brochures were observed in the lobby of the administration building. Postings include the phone number for the Texas Department of Family and Protective Services 1 (800) 252-5400. The call is toll free and posted on the bulletin boards in each resident cottage. Also posted is the phone number for the Brazos County Office of the Sheriff 1 (979) 361-4991.

The facility meets the requirements of standard 115.333.

Corrective Action Findings: None

Standard 115.334: Specialized training: Investigations

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

115.334 (a)

- In addition to the general training provided to all employees pursuant to §115.331, 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 115.321(a).)
  ☐ Yes ☐ No ☒ NA

115.334 (b)

- Does this specialized training include techniques for interviewing juvenile sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☐ Yes ☐ No ☒ NA

- Does this specialized training include proper use of Miranda and Garrity warnings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☐ Yes ☐ No ☒ NA

- Does this specialized training include sexual abuse evidence collection in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☐ Yes ☐ No ☒ NA

- Does this specialized training include the criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)
  ☐ Yes ☐ No ☒ NA

115.334 (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 115.321(a).)
  ☐ Yes ☐ No ☒ NA

115.334 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PAQ
b. Everyday Life Zero Tolerance Policy
c. Training Documentation (rosters and certificates)

Interviews included:

a. Program Director / PREA Coordinator
b. Random Staff
c. Specialized staff (EDL PREA Compliance Team members)
d. Contractors

Site Review / Observations:

a. None

115.334 (a) In accordance with EDL's Zero Tolerance Policy, EDL staff member cannot investigate allegations of sexual abuse, therefore this section is N/A. EDL staff do receive specialized training that includes:

a. Techniques for interviewing sexual abuse victims
b. Proper use of EDL incident protocol and reporting practices and
c. Assisting DPFS and Brazos County Sheriff when required

115.334 (b) Because investigations are the responsibility of DPFS and Brazos County Sheriff, EDL staff are not required to have specialized training including techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. For EDL, this section is N/A.

115.334 (c) EDL did not provide documented proof of the training DPFS and Brazos County Sheriff investigators receive. This section is N/A.

115.334 (d) Auditor is not required to audit this provision.

The facility meets the requirements of standard 115.334 (a-d).

Corrective Action Findings: None

Standard 115.335: Specialized training: Medical and mental health care

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

115.335 (a)

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

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

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

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

115.335 (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 *or* the agency does not employ medical staff.)
  ☐ Yes ☐ No ☒ NA

115.335 (c)

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

115.335 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
  ☒ Yes ☐ No ☐ NA

- Do medical and mental health care practitioners contracted by or volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PAQ
b. Everyday Life Zero Tolerance Policy
c. Training Documentation (rosters and certificates)

Interviews included:

a. Program Director / PREA Manager
b. Director of Administration / PREA Coordinator
c. Mental Health Contractors

Site Review / Observations:

a. None

115.335 (a) The EDL Zero Tolerance Policy (5, A-D) states that EDL ensures and maintains documentation that all full and part-tie medical and mental health practitioners who work in EDL operated facilities have been trained in how to:

1. How to detect and assess sins of sexual abuse and sexual harassment
2. How to preserve physical evidence of sexual abuse
3. How to respond effectively and professionally to juvenile victims of sexual abuse an sexual harassment
4. How and to whom to report allegations of sexual abuse and harassment

115.335 (b) EDL does not employ any medical staff. As a result no EDL staff are required to receive training related to forensic exams.

115.335 (c) During the interview of the EDL contracted mental health practitioner, he stated he received training related to PREA and the requirements of standard 115.335. The auditor observed an addendum to the mental health practitioners' contract that the mental health staff must stay current with PREA and Forensic examination training standards. The addendum was signed by both the agency and the contractor.

115.335 (d) Contractors for EDL are required to participate in the same PREA training mandated for employees under 115.331 and 115.332.

During the on-site phase of the audit, PREA Auditor were able to observe the intake process and the contracted mental health contractors interactions with intake staff and new residents.

The facility meets the requirements of standard 115.335 (a-d).

Corrective Action Findings: None

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.341: Screening for risk of victimization and abusiveness

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

115.341 (a)

- Within 72 hours of the resident's arrival at the facility, does the agency obtain and use information about each resident's personal history and behavior to reduce risk of sexual abuse by or upon a resident? ☒ Yes ☐ No

- Does the agency also obtain this information periodically throughout a resident's confinement? ☒ Yes ☐ No

115.341 (b)

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

115.341 (c)

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (1) Prior sexual victimization or abusiveness? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (3) Current charges and offense history? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (4) Age? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (5) Level of emotional and cognitive development? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (6) Physical size and stature? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (7) Mental illness or mental disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (8) Intellectual or developmental disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (9) Physical disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (10) The residents' own perception of vulnerability? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents? ☒ Yes ☐ No

115.341 (d)

- Is this information ascertained through conversations with the resident during the intake process and medical mental health screenings? ☒ Yes ☐ No

- Is this information ascertained during classification assessments? ☒ Yes ☐ No

- Is this information ascertained by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files? ☒ Yes ☐ No

115.341 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PAQ
b. Everyday Life Zero Tolerance Policy
c. Screening Instrument

Interviews included:

a. Program Director / PREA Manager
b. Intake Staff
c. Mental Health Contractors
d. Residents

Site Review / Observations:

a. Intake assessment and orientation process.

115.341 (a) The EDL Zero Tolerance Policy (h, 1, A) does list the process of within 72 hours after a youth's admission to EDL, EDL uses an objective screening instrument to obtain information about the youths personal history and behavior to reduce the risk of sexual abuse by or upon another youth. The policy (same section) also states that periodically throughout the youth's stay, information from the screening instrument is used to reassess housing and supervision assignments. When completing a file audit of randomly selected resident files, auditors found 100% of the files randomly selected had a risk screen completed within the 72 hour time period.

115.341 (b) In accordance with the EDL Zero Tolerance Policy and PREA standards, the facility intake screening is conducted by trained staff using an objective screening instrument. When completing a file audit of randomly selected resident files, auditors found 100% of the files randomly selected had a screen completed using an objective screening instrument.

115.341 (c) The screening instrument, used at EDL, if completed in its entirety did ascertain the following information:

1. Prior sexual victimization or abusiveness
2. Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore vulnerable to sexual abuse
3. Current charges and offense history
4. Age
5. Level of emotional and cognitive development
6. Physical size and stature
7. Mental illness or mental disabilities
8. Intellectual or developmental disabilities
9. Physical disabilities
10. The residents own perception of vulnerability
11. Any specific information about individual residents that may indicate heightened need for supervision, additional safety precautions, or separation from certain residents

115.341 (d) Through the file audits, staff interviews, resident interviews and an interview with the contracted psychological practitioner the auditors were able to ascertain that risk assessments are being done in all eleven areas listed in 115.341 (c). This information is collected from conversations with the resident and a review of court records, case files, facility behavioral records, and other relevant documentation that is gathered prior to the residents arrival at EDL. EDL is to be commended on the completeness of the resident files. A large amount of documentation is available in the resident binders after only 72 hours of screening, gathering, and generating the intake packet.

115l341 (e) The Program Director / PREA Coordinator and Intake staff indicated during interviews that the information obtained during the initial, and follow up screening is sensitive and treated as confidential, therefore the information has limited dissemination and access to prevent exploitation is controlled by double locking the paper files and password protecting the electronic records. Employees are only permitted to view the protected information on a need to know basis.

Based on the information learned in the interviews, document reviews, and the observations of the security in place to protect the confidential information, EDL is in compliance with standards of this section.

The facility meets the requirements of standard 115.341 (a-e).

Corrective Action Findings: Non

Standard 115.342: Use of screening information

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

115.342 (a)

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Housing Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Bed assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Work Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Education Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Program Assignments? ☒ Yes ☐ No

115.342 (b)

- Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

- During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

- Do residents in isolation receive daily visits from a medical or mental health care clinician? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

- Do residents in isolation also have access to other programs and work opportunities to the extent possible? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

115.342 (c)

- Does the agency always refrain from placing lesbian, gay, and bisexual (LGB) residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from placing transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from placing intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex (LGBTI) identification or status as an indicator or likelihood of being sexually abusive? ☒ Yes ☐ No

115.342 (d)

- 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

115.342 (e)

- Are placement and programming assignments for each transgender or intersex resident reassessed at least twice each year to review any threats to safety experienced by the resident? ☒ Yes ☐ No

115.342 (f)

- 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

115.342 (g)

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

115.342 (h)

- If a resident is isolated pursuant to provision (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

- If a resident is isolated pursuant to provision (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

115.342 (i)

- In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS? (N/A if the facility *never* places residents in isolation for any reason.)
  ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:
a. PAQ
b. Everyday Life Zero Tolerance Policy
c. Screening Instrument
d. Resident Files

Interviews included:
a. Program Director / PREA Manager
b. Intake Staff
c. Supervisory Staff
d. Random Residents

Site Review / Observations:

a. Intake assessment and orientation process.
b. Facility Tour - No isolation Rooms were observed.

115.342 (a) EDL's Zero Tolerance Policy (2 A) states that EDL uses all information obtained during intake screening to make housing, bed, program, education, and work assignments for youth. Intake staff as well as the Program Director / PREA Coordinator confirmed in interviews that information learned during intake screening is used to make informed housing assignments. Furthermore, the housing assignments are discussed anytime there is an incident and moving kids bed/room assignment may be considered an intervention.

115.342 (b) The EDL Zero Tolerance Policy prohibits the use of isolation, therefore EDL avoids isolating residents due to risk of sexual victimization. During the three days at the facility auditors walked freely through the facility and were given access to all areas as requested. At no time were isolation areas or isolation practices observed.

115.342 (c) When interviewed, the EDL Program Director and Intake Staff explained EDL does not place LGBTQ residents on a special housing status/assignment or identification status as an indicator of vulnerability for sexual assault or harassment. Throughout both staff and resident interviews, no one reported EDL having a LGBTQ resident for the past 12 months, therefore there were no bed assignment records or screening instruments to evaluate for this standard. The agency staff reported that if LGBTQ youth were in the program EDL would always refrain from considering lesbian, gay, bisexual, transgender, or intersex (LGBT) identification or status as an indicator or likelihood of being sexually abusive?

115.342 (d) The Intake Staff and Facility Managers reported no LGBTQ residents in the past 12 months. Those staff interviewed stated the bed/housing assignments are made on a case by case basis and as with all youth the assignment would be based on ensuring the residents health and safety, and whether placement would present management or security problems.

115.342 (e) At the time of the audit there were no residents who identified as LGBTQ at the facility. The program Zero Tolerance Policy (h) (ii) states resident housing assignments and programing assignments are reassessed at least twice each year to review any threats to safety experienced by the youth.

115.342 (f) At the time of the audit there were no residents who identified as LGBTQ at the facility, therefore the auditors could not interview a resident in respect to them feeling like their own views were being considered in regard to housing assignments. The programs screening instrument used for all admissions does take into consideration the residents own views with respect to his or her own safety.

115.342 (g) EDL's Zero Tolerance Policy (h) (i) provides the opportunity for all residents to shower separately from other youth. During the facility tours it auditors observed the shower areas. They were all single user shower rooms behind a locked door for complete resident privacy.

115.342 (h) EDL has no isolation area/room and no staff or resident reported the use of isolation at EDL. This section is therefore not applicable.

115.342 (i) EDL has no isolation area/room and no staff or resident reported the use of isolation at EDL. The Chief Executive Officer and Program Director / PREA Coordinator confirmed in their separate interviews that isolation is not part of the EDL facility program.

Based on the information learned in the interviews, document reviews, and the observations of the auditors, EDL is in compliance with standards of this section.

The facility meets the requirements of standard 115.342 (a – i).

Corrective Action Findings: None

REPORTING

Standard 115.351: Resident reporting

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

115.351 (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

115.351 (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

- Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment? (N/A if the facility *never* houses residents detained solely for civil immigration purposes.) ☐ Yes ☐ No ☒ NA

115.351 (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

115.351 (d)

- Does the facility provide residents with access to tools necessary to make a written report? ☒ Yes ☐ No

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:
a. PAQ
b. Everyday Life Zero Tolerance Policy
c. Screening Instrument
d. Resident Files

Interviews included:
a. Program Director / PREA Manager
b. Director of Administration / PREA Coordinator
c. Intake Staff
d. Supervisory Staff
e. Random Residents

Site Review / Observations:
a. Intake assessment and orientation process.
b. Facility Tour - No isolation Rooms were observed.

115.351 (a) Everyday Life Residential Treatment Center provides multiple internal ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff including staff neglect or violation of responsibilities that may have contributed to such incidents. The EDL Zero Tolerance Policy lists the following ways to report:
1. Submitting a written grievance, verbally or by any means the youth has access to
2. Calling the 24-hour toll free hotline 1 800-252-5400 without being heard by staff or other youth
3. Telling any staff member, volunteer, or contract employee who must then call the hotline and inform the Administer or Deputy Administrator

4. Calling the toll free number maintained by the Texas Department of Family Protective Services which is a separate state agency. Also without being heard by staff or residents

115.351 (b) As written in section (a), residents may call the toll-free number maintained by the Texas Department of Family Protective Services, 1 (800) 252-5400, which is a separate state agency. Staff and resident interviews revealed that this call could be made without being heard by staff or residents

115.351 (c) EDL staff training included the protocol for staff when a resident reports sexual abuse or harassment. The protocol, as listed in the Zero Tolerance Policy, states that EDL staff promptly accepts verbal and written reports made anonymously or by third parties and promptly document any verbal reports.

115.351 (d) EDL provides residents access to grievance forms, writing instruments, to privately make a written report. Auditors observed grievance forms available and grievance boxes present. Auditors observed grievance forms and pencils on the facility tour. In interviews 13 of 13 residents reported that they believed they could file a confidential grievance or allegation of abuse/harassment.

115.351 (e) EDL staff are trained that they can utilize the hotline numbers or call the Brazos County Sheriff's department directly if they suspect or receive an allegation of sexual abuse or harassment. 19 of 19 staff reported they were trained on how to utilize the hotline numbers if they suspected or received an allegation of sexual abuse or harassment.

Based on the information learned in the resident and staff interviews, document reviews, and the observations of the auditors, EDL is in compliance with standards of this section.

The facility meets the requirements of standard 115.3451 (a – d).

Corrective Action Findings: None

Standard 115.352: Exhaustion of administrative remedies

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

115.352 (a)

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

115.352 (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

115.352 (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

115.352 (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 115.352(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

115.352 (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, other than a parent or legal guardian, 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

- Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (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

115.352 (g)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PAQ
b. Everyday Life Zero Tolerance Policy
c. Resident Handbook
d. Grievance Policy
e. Grievance log
f. Resident Files
g. Third Party Reporting Forms

Interviews included:

a. Program Director / PREA Manager
b. Intake Staff
c. Supervisory Staff
d. Random Residents

Site Review / Observations:

a. Intake assessment and orientation process.

115.352 (a) This standard does apply to EDL because EDL does have administrative procedures to address resident grievances regarding sexual abuse and harassment.

115.352 (b) Per the EDL Zero Tolerance Policy (2) (A), EDL reports all allegations of sexual abuse regardless of how much time has passed since the alleged incident. While at EDL, residents are not required to use the grievance system or the informal conference request system to report an allegation of sexual abuse or harassment. Furthermore, the residents are not required to attempt to resolve the allegation with staff.

115.352 (c) In accordance with EDL policy and as confirmed in the resident and staff interviews:

1. A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint.
2. Such grievances are not referred to a staff member who is the subject of a complaint.

115.352 (d)

1. All grievances and allegations related to sexual abuse and harassment are referred rto EDFPS and the Brazos County Sheriff's office. Both agencies acknowledge the expected PREA guidelines and complete their portion of the investigation as soon as possible. This allows EDL to 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.

2. The EDL Program Director / PREA Coordinator acknowledged that if the they determined that the 90-day timeframe is insufficient they would refer to the PREA standards and make an appropriate decision and claim an extension of time and notify the resident in writing of any such extension and provide a date by which a decision will be made. Through interviews of residents, interviews of staff, and a review of the grievances of the past 12 months the auditors found zero allegations or grievances related to sexual abuse or harassment.

3. Although unlikely, if all of the time limits of 1 and 2 of this section (d) are exhausted and the resident does not receive a written response the youth could contact his lawyer or the State ombudsman's office.

115.352 (e) EDL accepts verbal and written reports made anonymously or by third parties and promptly documents verbal reports. EDL publicly distributes information on the company web site.

1. According to EDL's Zero Tolerance Policy, 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. Third party forms were observed and available to the public during the auditor's tour of the EDL facility.

2 Third parties are permitted to file such requests on behalf of residents.

3 If a resident were to decline to have a third-party request processed on his or her behalf, EDL would document the resident's decision.

4. EDL accepts third party allegations and grievances from anyone, this includes the parent or legal guardian of a juvenile.

5. The EDL Program Director / PREA Coordinator and Chief Executive Officer made it clear all allegations of sexual abuse and harassment are taken seriously and followed up per PREA standards. No grievances would be conditioned upon the juvenile agreeing to have a request filed on his behalf.

115.352 (f)

1. EDL has confidential grievance boxes and has an open-door policy to the Chief Executive Officer and Program Director's office. Auditors observed residents using this avenue to talk to both administrators in private. This procedure meets the standard of having an established procedure for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse.

2. EDL's administrators maintain constant communication with the direct care staff and residents. Any grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, would be immediately reviewed at the highest level and forwarded to licensing and the Brazos County Sheriff for processing. All staff interviewed mentioned separating a resident from a situation that had imminent risk of sexual abuse.

3. After receiving an emergency grievance, the either the Chief Executive Officer, Program Director, or a licensed clinical staff would provide an initial response within 48 hours.

4. Because EDL does not conduct any investigations and any grievance related to sexual abuse and harassment would be turned over to the authorities, they are exempt from the standards listed in #5,6, and 7 of this section. EDL did demonstrate a high level of priority related to appropriately communicating with residents on all resident concerns.

115.352 (g) EDL's Zero Tolerance Policy does not state that the agency may discipline a resident for filing a grievance related to alleged sexual abuse if the resident filed the grievance in bad faith. The EDL Program Director / PREA Coordinator did show no youth had been disciplined for filing any grievance in bad faith. A review of the grievances filed over the past 12 months showed zero grievances alleging sexual abuse or harassment.

There were zero grievances filed for the purpose of reporting sexual abuse or harassment. In the interviews the residents all reported feeling safe at EDL and that they could file an allegation without fear of retaliation. The staff interviews revealed that all of the staff were aware of the resident and third part grievance procedures. The grievance procedure has multiple ways of filing and has an appeal level.

The facility meets the requirements of standard 115.3452 (a – g).

Corrective Action Findings: None

Standard 115.353: Resident access to outside confidential support services and legal representation

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

115.353 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making assessible 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 provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies? (N/A if the facility *never* has persons detained solely for civil immigration purposes.) ☐ Yes ☐ No ☒ NA

- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? ☒ Yes ☐ No

115.353 (b)

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

115.353 (c)

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

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

115.353 (d)

- Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation? ☒ Yes ☐ No

- Does the facility provide residents with reasonable access to parents or legal guardians? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PAQ
b. Everyday Life Zero Tolerance Policy
c. SARC Brochure and MOU
d. PREA Posters
e. Facility Schematics of visitation space
f. Resident Handbook

Interviews included:

a. Program Director / PREA Manager
b. Intake Staff
c. Supervisory Staff
d. Random Residents
e. SARC Staff
f. Therapist

Site Review / Observations:

a. Telephone locations and resident ability to make confidential calls.
b. Rooms provided for confidential resident meetings with lawyers, advocates, and parents.

115.353 (a) The Everyday Life (EDL) Zero Tolerance Policy (3) (A-C) outlines how all residents have access to outside confidential support services related to sexual abuse and harassment. EDL provides information through resident cottage and administration building postings that include mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations. 13 of 13 residents interviewed confirmed they believed a call to outside support services would be private and confidential. 19 of 19 staff interviewed confirmed residents were provided private and confidential phone calls upon request.

Auditors observed the following phone numbers posted in the resident cottages:

- Brazos County Office of the Sheriff (1 979 361-4991)
- The Texas Department of Family and Protective Services (1 800 252-5400)

The facility also provides residents with information about outside victim advocates for emotional support services by giving the residents brochures for the SARC (Sexual Assault Resource Center). The SARC brochure does include a mailing address for residents to correspond by mail. This auditor called the phone number on the brochure and spoke to a hotline staff about the services offered to callers. The SARC reported no calls on record from EDL in the past 12 months.

EDL does not provide services for youth detained solely for civil immigration purposes, therefore no postings or brochures include contact information for immigration services.

115. 353 (b) 13 of 13 residents reported during their interviews that upon admission they received information on how to access outside confidential support services and that they believed the calls were confidential. 13 of 13 residents, 2 of 2 specialty intake staff, and 2 of 2 therapist confirmed the residents are informed of the mandatory reporting rules, governing privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant Federal, State, or local law. 2 of 2 therapist recited the verbal notification they recite before discussing sexual abuse and sexual harassment with the residents.

Auditors observed the PREA posters with toll free numbers to access confidential support services. Auditors tested the phone numbers and confirmed the process was established and working. 19 of 19 EDL staff and management confirmed in their respective interviews that the resident phone calls are not monitored or recorded.

115.353 (c) EDL provided a copy of an MOU with Scotty's House Brazos Valley Child Advocacy Center and with the Sexual Assault Resource Center to provide residents with confidential emotional support services related to sexual abuse and harassment. Both outside agencies provide emotional support services to members of the public, including residents of Everyday Life, free of charge. Services can be provided in-person or by phone.

115.353 (d) EDL's Zero Tolerance Policy (3) (A-C) states that EDL does provide residents with reasonable and confidential access to their attorneys or legal representation, parents, and legal guardians. Auditors observed the meeting rooms used for such visits and determined them to be in compliance with this standard. All of the residents interviewed could explain how they could meet with their legal representatives, parents, and legal guardians in a confidential manner.

In the interviews 13 of 13 residents all reported feeling safe at EDL and that they could make confidential contact with legal representatives and to receive emotional support services as needed. During the multiple facility tours auditors observed postings in areas commonly used by residents and observed meeting rooms used for confidential visits between residents and parents and or legal representatives.

The facility meets the requirements of standard 115.3453 (a – d).

Corrective Action Findings: None

Standard 115.354: Third-party reporting

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

115.354 (a)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PAQ
b. Everyday Life Zero Tolerance Policy
c. PREA Posters
d. SARC Brochure
e. Scotty's House MOU
f. 3rd Party Reporting Form

Interviews included:

a. Program Director / PREA Coordinator
b. Random Residents
c. Random Staff
d. SARC Staff
e. Therapist

Site Review / Observations:

a. Postings
b. Availability of Third-Party Reporting forms.
c. Agency Web Site

115.354 The EDL Zero Tolerance Policy describes the procedures for to receive and for making a 3rd party report of sexual abuse and harassment on behalf of a youth.

Auditors observed the posting of the 3rd party reporting procedure on the agency web site.

Documentation reviewed included the 3rd party grievance form provided to facilitate 3rd party reporting of sexual abuse and harassment on behalf of a resident. The EDL web site includes directions for third party individuals to file a complaint or allegation of sexual abuse or harassment.

The facility meets the requirements of standard 115.354.

Corrective Action Findings: None

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.361: Staff and agency reporting duties

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

115.361 (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

115.361 (b)

- Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws? ☒ Yes ☐ No

115.361 (c)

- Apart from reporting to designated supervisors or officials and designated State or local services agencies, are staff prohibited 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

115.361 (d)

- Are medical and mental health practitioners required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws? ☒ Yes ☐ No

- Are medical and mental health practitioners required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services? ☒ Yes ☐ No

115.361 (e)

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office? ☒ Yes ☐ No

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified? ☒ Yes ☐ No

- If an alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? ☒ Yes ☐ No

- If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation? ☒ Yes ☐ No

115.361 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. PAQ
b. Everyday Life Zero Tolerance Policy
c. PREA Posters
d. SARC Brochure
e. Scotty's House MOU
f. 3rd Party Reporting Form

Interviews included:

a. Program Director / PREA Coordinator
b. Random Residents
c. Random Staff
d. SARC Staff
e. Intake Staff

Site Review / Observations:

a. Postings

115.361 (a) EDL's Zero Tolerance Policy does 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. The EDL policy also requires all staff to report immediately any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment. In staff interviews the staff consistently explained they were trained 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.

115.361 (b) EDL policy and training supports the requirement all staff to comply with any applicable mandatory child abuse reporting laws.

115.361 (c) Apart from reporting to designated supervisors or officials and designated State or local services agencies, the EDL Zero Tolerance Policy (J) (1-8) establishes the policy that staff are prohibited 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.

115.361 (d) EDL does not have any medical staff, but the mental health practitioners reported that they are required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws. The mental health practitioners are required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services. During one interview a mental health practitioner recited his introduction he says to each resident before every therapy session. It included the limitations on confidentiality and his duty to report if appropriate.

115.361 (e) Upon receiving any allegation of sexual abuse, does the Chief Executive Officer or designee Program Director / PREA Coordinator promptly report the allegation to the Department of Family Protective Services and the Brazos County Sheriff. During their interviews both the CEO and PD demonstrated extensive knowledge of the reporting process.

If the Director of Administration, Program Director or any other management staff received any allegation of sexual abuse, they would promptly report the allegation to the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified or are alleged to be involved in the sexual abuse or harassment. If an alleged victim is under the guardianship of the child welfare system, does the CEO and PD would promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians. If a juvenile court retains jurisdiction over the alleged victim, the CEO or PD would report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation.

Both the Chief Executive Officer and Program Director / PREA Coordinator explained they would immediately notify all of the residents representatives as appropriate on a case by case basis.

115.361 (f) The EDL Zero Tolerance Policy states that all allegations of sexual abuse and harassment (including 3rd party reports) must be immediately reported to TDFPS and the Brazos County Sheriff's Office. Those agencies are the designated investigation agencies.

The facility meets the requirements of standard 115.361 (a-f).

Corrective Acton Required: None

Standard 115.362: Agency protection duties

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

115.362 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:
a. PAQ
b. Everyday Life Zero Tolerance Policy

Interviews included:
a. Director of Administration
b. Program Director / PREA Manager
c. Random Residents
d. Random Staff
e. Intake Staff

Site Review / Observations:
a. Public Postings

115.362 (a) Interviews of random staff as well as administrators revealed the staff of Everyday Life Residential Treatment Center clearly understand that when anyone learns that a resident is subject to a substantial risk of imminent sexual abuse they must take immediate action to protect the resident. The EDL Zero Tolerance Policy supports this standard. All staff interviewed discussed separating a resident that was at risk. Because the facility does not utilize isolation the separation procedures discussed included removing the resident from his assigned cottage, providing one on one supervision, and removing the other person who is causing the imminent risk of sexual abuse or harassment.

The facility meets the requirements of standard 115.362.

Corrective Action: None

Standard 115.363: Reporting to other confinement facilities

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

115.363 (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

- Does the head of the facility that received the allegation also notify the appropriate investigative agency? ☒ Yes ☐ No

115.363 (b)

- Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation? ☒ Yes ☐ No

115.363 (c)

- Does the agency document that it has provided such notification? ☒ Yes ☐ No

115.363 (d)

- Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:
a. PAQ
b. Everyday Life Zero Tolerance Policy

Interviews included:
a. Program Director / PREA Coordinator
b. Random Staff
c. Intake Staff

Site Review / Observations:
a. None

115.363 (a)The Everyday Life Zero Tolerance Policy supports PREA standard 115.363. Upon receiving an allegation that a resident was sexually abused while confined at another facility, the administrator receiving the allegation does notifies TDFPS immediately and then the head of the facility or appropriate office of the agency where the alleged abuse allegedly occurred.

115.363 (b)The EDL Zero Tolerance Policy lists that the notification to the head of the facility where the abuse allegedly occurred must be notified within 72 hours after receiving the allegation.

115.363 (c) EDL resident documents and logs appeared to be very well organized and substantially complete when reviewed by the auditors. There was no evidence of documentation that abuse allegations related to other facilities was made because there were allegations of abuse or harassment reported in the past 12 months.

115.363 (d) Both the Program Director / PREA Coordinator and Chief Executive Officer explained their knowledge of the reporting requirements related to sexual abuse and harassment. They both made it clear they would report any allegation and make sure the report was investigated in accordance with all PREA standards.

The facility meets the requirements of standard 115.363.

Corrective Action Required: None

Standard 115.364: Staff first responder duties

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

115.364 (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

115.364 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:
Documents reviewed included:

a. PAQ
b. Everyday Life Zero Tolerance Policy
c. EDL Staff PREA Training

Interviews included:

a. Director of Administration
b. Program Director / PREA Manager
c. Random Staff
d. First Responder Staff

Site Review / Observations:

a. None

115.364 (a) Upon learning of an allegation that a resident was sexually abused, the EDL first staff member to respond to the report is required to separate the alleged victim and abuser. This practice is supported in the EDL Zero Tolerance Policy and was recited by all staff in the random staff and first responder interviews.

Upon learning of an allegation that a resident was sexually abused, the first staff member to respond to the report is also required to: preserve and protect any crime scene until appropriate steps can be taken to collect any evidence. This practice is supported in the EDL Zero Tolerance Policy and was recited by all staff in the random staff and first responder interviews.

Upon learning of an allegation that a resident was sexually abused, the first staff member to respond to the report is 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. This practice is supported in the EDL Zero Tolerance Policy and was recited by all staff in the random staff and first responder interviews.

Upon learning of an allegation that a resident was sexually abused, is the first staff member to respond to the report is 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. This practice is supported in the EDL Zero Tolerance Policy and was recited by all staff in the random staff and first responder interviews.

115.364 (b) Everyday Life is a Residential Treatment Center and does not have designated “security staff.” All staff are trained to respond in the same manner. All responders are trained to separate the alleged victim from imminent risk, request that the alleged victim not take any actions that could destroy physical evidence, and then report the incident per policy.
Everyday Life Residential Treatment Center had zero incidents of alleged sexual abuse or harassment in the past 12 months. The standard used to determine compliance with this standard was the Zero Tolerance Policy, staff training curriculum, and staff interviews.

The facility meets the requirements of standard 115.364.

Corrective Action Required: None

Standard 115.365: Coordinated response

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

115.365 (a)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:
Documents reviewed included:

a. Everyday Life Zero Tolerance Policy
b. EDL Staff PREA Training

Interviews included:
a. Director of Administration
b. Program Director / PREA Coordinator
c. Random Staff
d. First Responder Staff

Site Review / Observations:
b. None

The EDL Zero Tolerance Policy outlines the procedures for specific staff's response to allegations of sexual abuse and sexual harassment. Each position at EDL has a role and specific action they are expected to take including first responders, mental health staff, administrators, and leadership. The Program Director / PREA Coordinator clearly explained the facilities coordinated response plan.

The facility meets the requirements of standard 155.365.

Corrective Action Required: None

Standard 115.366: Preservation of ability to protect residents from contact with abusers

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

115.366 (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

115.366 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. Everyday Life Zero Tolerance Policy
b. Memo to Auditor Regarding Collective Bargaining at Everyday Life
c. Staff files

Interviews included:
a. Executive Director
b. Program Director
c. Random Staff

Site Review / Observations:
a. None

115.366 (a) Per the memo, from Executive Director Cedric Payton, provided to the auditors and supported in staff interviews, EDL does not employ unionized employees therefore EDL does not participate in collective bargaining. EDL policy states alleged sexual abusers or harassers can be removed from contact with residents pending investigations and/or final outcomes, including discipline that is warranted, related to allegations of sexual abuse and harassment.

Interviews of the Executive Director, Program Director, and Random Staff provided no evidence that EDL participates in collective bargaining processes.

115.366 (b) The auditor is not required to audit this provision.

Through staff interviews, file audits, and the memo from the Director of Adminstration the facility meets the requirements of standard 115.366.

Corrective Action Required: None

Standard 115.367: Agency protection against retaliation

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

115.367 (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

115.367 (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

115.367 (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

115.367 (d)

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

115.367 (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

115.367 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. EDL Zero Tolerance Policy
b. EDL PAQ
c. Staff files

Interviews included:

a. Executive Director / Staff Responsible for Monitoring Retaliation
b. Program Director
c. Random Staff

Site Review / Observations:

a. None

115.367(a)
EDL has a policy providing protection against retaliation 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. EDL Zero Tolerance Policy page 10 section 7). The Executive Director and Program Director are the staff designated to monitoring retaliation against staff or residents that report sexual abuse or harassment.

115.367(b)
Section (7) (B) on page 10 of the EDL Zero Tolerance Policy states the agency employs 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. During the on-site audit, this auditor observed discussions on moving residents from one cottage to another to avoid incidents based on disagreements between peers. This was not sexual abuse or sexual harassment related, however it was a demonstration that EDL did implement proactive protection/intervention measures to avoid incidents.

115.367(c, d, e)
The EDL Zero Tolerance Policy has provision on page 10 section (7) (C) that at least 90 days (except when the allegation is unfounded): the staff employed with protecting residents from retaliation monitors the reporter and the alleged victim for signs of retaliation including items such as disciplinary reports, housing or program changes, staff reassignments, and negative performance reviews and conducts periodic status checks on the alleged victim and act promptly to remedy any retaliation.

Because there were zero reported allegations of sexual abuse or sexual harassment during the last 48 months, auditors Howell and Williams were unable to review documentation which would prove or disprove compliance with this standard. Interviews of the key staff designated as those responsible for monitoring for retaliation resulted in both individuals able to explain measures they would employ to protect residents.

As a result of the evidence considered, the facility meets the requirements of this standard.

Corrective Action Required: None

Standard 115.368: Post-allegation protective custody

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

115.368 (a)

- Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342? ☐ Yes ☒ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. EDL Zero Tolerance Policy
b. EDL PAQ
c. Facility Schematic
d. Incident reports
e. Resident Files

Interviews included:
a. Director of Administration / PREA Coordinator
b. Program Director / PREA Manager
c. Random Staff
d. Random Residents

Site Review / Observations:
b. Resident Cottages 1, 2, 3

115.368 (a)
EDL does not have or implement the use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342. As observed on the facility tour, EDL does not have segregated housing in the cottages the residents reside.

The EDL Zero Tolerance Policy (page 11, 8) states EDL does not use segregation housing to protect a youth who is alleged to have suffered sexual abuse. In the past 12 months:

The number of residents who allege to have suffered sexual abuse who were placed in isolation: 0

The number of residents who allege to have suffered sexual abuse who were placed in isolation who have been denied daily access to large muscle exercise, and/or legally required education, or special education services: 0

The average period of time residents who allege to have suffered sexual abuse who were held in isolation to protect them from sexual victimization: 0

Documentation reviewed to determine compliance included incident reports and resident case files to determine if isolation is used at all at EDL. Interviews included the Director of Administration, Random staff, the Program Director, and Random Residents. Observations included each building on campus to determine if there was an isolation area. Auditors could not find evidence that isolation is used at EDL.

As a result of the evidence considered, the facility meets the requirements of this standard.

Corrective Action Required: None

INVESTIGATIONS

Standard 115.371: Criminal and administrative agency investigations

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

115.371 (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 115.321(a).] ☐ Yes ☐ No ☒ NA

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] ☐ Yes ☐ No ☒ NA

115.371 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334? ☒ Yes ☐ No

115.371 (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

115.371 (d)

- Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation? ☒ Yes ☐ No

115.371 (e)

- 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

115.371 (f)

- 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

115.371 (g)

- 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

115.371 (h)

- 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

115.371 (i)

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

115.371 (j)

- Does the agency retain all written reports referenced in 115.371(g) and (h) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention? ☒ Yes ☐ No

115.371 (k)

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

115.371 (l)

- Auditor is not required to audit this provision.

115.371 (m)

- When an outside agency 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 115.321(a).) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. Zero Tolerance Policy
b. Memorandum of Agreement between Brazos County Sheriff's Office and EDL
c. General Residential Operating Manual
d. Student Files
e. Staff Files

Interviews included:
a. Chief Executive Officer
b. Program Director / PREA Coordinator
c. Random Staff

Site Review / Observations:
a. N/A

115.371 (a)
The EDL Zero Tolerance Policy (page 11, k) states that EL does not conduct investigations for any allegations of sexual abuse or rape including third party and anonymous reports. Auditors reviewed and received a copy of a Memorandum of Agreement, dated August 28, 2019 between Everyday Life and The Brazos County Sheriff's Office. The agreement states that in accordance with PREA Standard 115.37, all criminal investigations shall be conducted by the Brazos County Sheriff's Office.

When interviewed the Director of Administration and the Program Director (both designated on the incident response team) explained that when an allegation is made they first ensure the alleged residents involved are safe and the potential crime scene is not disturbed. They then call the Brazos County Sheriff's department as soon as possible. When asked specifically how long it takes to initiate an investigation the Director of Administration replied, "we call within the hour of learning of the allegation." The Program Director replied, "If I call the Sheriff's department they can be out here in minutes."

Both the Director of Administration and the Program Director said anonymous or third part allegations would not be treated any different than any other allegation of sexual abuse or harassment.

There were no investigation documents to review because there were no allegations of sexual abuse or harassment in the past 12 months.

115.371 (b, c, i,)
As listed above, EDL delegates all investigations related to sexual assault investigations to the TDFPS and Brazos County Sheriff's Office. During the on-site portion of the audit the EDL Chief Executive Officer provided a copy of a Memorandum of Agreement between Everyday Life and the Brazos County Office of the Sheriff. The memorandum specifically states that the Sheriff's Office is responsible for all criminal investigations and that the investigations are conducted in accordance with the provisions of PREA 115.371 Criminal and Administrative Investigations. The EDL Zero Tolerance Policy (k) (B) states that "for investigations of alleged sexual abuse, EDL reports to TDFPS/BCOS who have received special training in sexual abuse investigations involving juvenile victims.

Brazos County Chief Deputy Stewart reported that he supervised investigator Trey Oldham. Investigator Oldham was the departments sexual assault investigation expert. Chief Deputy Steward explained the following:

a. Officer Oldham is required to stay current on sexual assault training techniques and relevant information.
b. Training has included:
    - Techniques for interviewing juvenile sexual abuse victims.
    - Proper use of Miranda and Garrity warnings.
    - Sexual abuse evidence collection in confinement settings.
    - Th criteria and evidence required to substantiate a case for administrative or prosecution referral.
c. The BCSO investigation process, including gathering of evidence.
d. Investigation relate to juveniles are initiated immediately upon receiving a report.
e. Third party or anonymous reports of sexual abuse or sexual harassment are not handled any different.
f. The Brazos County District Attorney is consulted throughout all investigations in case prosecutions are the end result of the investigations.
g. Polygraph examinations or truth telling devices are not used in juvenile cases.

Additionally, during an interview of the local SANE certified nurse (Niki Johnson) at Baylor Scott & White Medical Center, the Nurse explained she works closely with the investigators from the Brazos County Office of the Sheriff. Interactions include providing special training in sexual abuse investigations involving juveniles.

115.371 (d)
EDL management (Director of Personnel, Program Director, and Director of Administration) reported in their separate interviews that EDL would refrain from terminating an investigation solely because the source of the allegation recants the allegation. Niki Johnson, the Baylor White & Scott hospital SANE lead forensic nurse, the SARC hotline staff, Brazos County Sheriff's Office Chief Deputy Jim Stewart, and TDFPS agent #5005 Dana reported zero allegations of sexual assault or sexual harassment in the past 12 months. The SANE nurse said there had been a referral in the past, but could not remember how long ago. Because EDL did not have any closed investigations reported, the auditors could not ascertain a reason to determine non-compliance with this provision.

Brazos County Chief Deputy Jim Stewart reported in his interview that the Sherriff's department does not terminate any investigations solely because the source of the allegation recants the investigation.

115.371 (e)
The facility reported zero allegations of sexual abuse or harassment, therefore there were zero investigations for the auditor to review. EDL management staff did report they would do nothing related to an on-going investigation unless it was pre-approved or requested by the investigating agency.

Chief Deputy Jim Stewart of the Brazos County Sheriff's Office reported that his department consults the Brazos County District Attorney Office throughout all sexual assault investigations in case the investigations result in criminal prosecution. This constant communication allows the investigators to receive consultation on processes such as whether to conduct compelled interviews.

115.371 (f)
Everyday Life (EDL) accepts all allegations of abuse or harassment regardless of 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. All allegations are submitted to TDFPS and BCOS. When interviewed, EDL Program Director / PREA Coordinator, Director of Personnel, and the Director of Administration confirmed EDL does not judge the person or the allegations, nor require a polygraph or other truth telling device as a condition for proceeding…both stated they immediately would forward it to the proper authorities as listed in the Zero Tolerance Policy.

When interviewed, Brazos County Chief Deputy Jim Steward explained "all allegations of sexual abuse and harassment are treated with the same priority but individually" regardless of the staff or resident's status. He also explained polygraph examinations or truth telling devices are not used in juvenile cases.

115.371 (g,h,j))
Facility management reported that there have been no allegations and subsequent investigations into sexual abuse or harassment in the past 12 months. PREA auditors Howell and Williams could not find evidence of any allegations or investigations while conducting resident file audits and written resident grievances. The facility managers reported they remain ready to, when appropriate, to determine whether staff actions or failures to act contributed to the abuse. Also, the they will make sure administrative investigations are 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. Because there were zero investigations, auditors were unable to determine compliance or non-compliance as to whether criminal investigations were 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.

According to the EDL Zero Tolerance Policy, ED retains all written criminal and administrative reports for a minimum of 10 years. EDL management reported that in the case of investigations such as those referenced in 115.371(g) and (h) they would retain those files as long as the abuser is incarcerated or employed 5 years plus according to their policy and applicable law.

115.371 (k)
Everyday Life does not conduct sexual abuse investigations, therefore has no control on the progress or outcome. As confirmed in Chief Deputy Steward's interview, the Brazos County Sheriff's Office does not terminate an investigation based on the departure of an alleged abuser or victim from the employment at EDL or control of the agency does not provide a basis for terminating an official investigation.

115.371 (l)
Auditor is not required to audit this provision.

115.371 (m)
13 of 13 staff interviewed and the Zero Tolerance Policy (k) (1) (c) (iii) confirmed the Everyday Life residential treatment center would cooperate with outside sexual abuse investigators and endeavor to remain informed about the progress of the investigation as appropriate. 13 of 13 staff confirmed they would participate in the investigation as requested by the outside agency. The Superintendent, Program Director both replied that they would fully cooperate with outside agencies investigating sexual abuse and harassment at EDL and would remain involved until the investigation was complete. .

Based on the documentation reviewed and information learned from EDL interviews and outside agency interviews the auditors determined EDL is compliant with the standard.

The facility meets the requirements of standard 115.371

Corrective Action Required: None

Standard 115.372: Evidentiary standard for administrative investigations

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

115.372 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. Zero Tolerance Policy
b. Memorandum of Agreement between Brazos County Sheriff's Office and EDL
c. General Residential Operating Manual
d. Student Files
e. Staff Files

Interviews included:
a. Director of Administration / PREA Coordinator
b. Program Director / PREA Compliance Manager
c. Random Staff
d. Investigative Staff (Brazos County Sheriff)

Site Review / Observations:
b. N/A

115.372 (a)
EDL delegates all investigations related to sexual assault investigations to the TDFPS and Brazos County Sheriff's Office. During the on-site portion of the audit the EDL Chief Executive Officer provided a copy of a Memorandum of Agreement between Everyday Life and the Brazos County Office of the Sheriff. The memorandum specifically states that the Sheriff's Office is responsible for all criminal investigations and that the investigations are conducted in accordance with the provisions of PREA 115.371 Criminal and Administrative Investigations.

Facility management reported no allegations or investigations in the past 12 months. Outside agencies reported no knowledge of EDL related allegations or investigations in the past 12 months.

There were no reported allegations or investigations during the past 12 months, therefore the auditors could not review sample investigative documents to determine a level of non-compliance with this standard.

As a result of the above information, EDL does not impose any evidentiary standard, let alone a higher standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

Based on the evidence gathered through document reviews, interterviews of EDL staff, and interviews of outside investigative agencies, auditor determined EDL does not perform administrative or criminal investigations.

The facility meets the requirements of standard 115.372 (a)

Corrective Action Required: None

Standard 115.373: Reporting to residents

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

115.373 (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

115.373 (b)

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

115.373 (c)

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

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

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

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

115.373 (d)

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

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

115.373 (e)

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

115.373 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. Zero Tolerance Policy
b. General Residential Operating Manual
c. Student Files
d. Staff Files

Interviews included:
a. Director of Administration / PREA Coordinator
b. Program Director / PREA Compliance Manager
c. Random Staff
d. Random Residents (there were zero who reported sexual abuse or harassment)

Site Review / Observations:
a. N/A

115.373 (a) EDL's Zero Tolerance Policy (page 11, section 2 Reports to Youth) outlines the facilities procedures for informing a resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. When interviewed the Director of Administration explained EDL does notify a resident of the outcome of an investigation. Chief Deputy Jim Stewart of the Brazos County Sheriff's Office replied "yes" when asked if his department would share the outcome of an investigation with the EDL staff and the resident making the allegation.

115.373 (b) EDL does not conduct investigations, the agency Zero Tolerance Policy (page 11, section 2, A) states EDL management “will request the information from the investigating agency so the youth may be informed.” There were no investigations reported during the past 12 months, therefore there were no outcomes and notifications to verify.

115.373 (c) EDL Zero Tolerance Policy (page 11, section 2, B) states that following a youths allegation that a staff member committed sexual abuse against the youth, EDL informs the youth whenever the following events occur, except when the allegation is determined to be unfounded:

(1) The staff member is no longer posted within the youths housing unit
(2) The staff member is no longer employed at the facility
(3) EDL learns that the staff member has been indicted on a charge related to sexual abuse or
(4) EDL learns that the staff member has been convicted on a charge related to the sexual abuse

The facility administration did not have any examples of documented proof of resident notification (in accordance with 115.373 (c) because there were no reported allegations. Auditors were unable to interview residents who reported sexual abuse because there were no allegations of abuse or harassment reported for the past 12 months.

115.373 (d) EDL Zero Tolerance Policy (page 11, secton 2, C) includes the following language – Following a youth’s allegation that he/she has been sexually abused by another youth, EDL informs the alleged victim whenever the following events occur:

(1) EDL learns that the alleged abuser has been indicted on a charge related to the sexual abuse; or
(2) EDL learns that the alleged abuser has been convicted on a charge related to the sexual abuse.

The facility administration did not have any examples of documented proof of resident notification (in accordance with 115.373 (d) because there were no reported allegations. Auditors were unable to interview residents who reported sexual abuse because there were no allegations of abuse or harassment reported for the past 12 months.

115.373 (e) The facility administration did not have any examples of documented proof of resident notifications (in accordance with 115.373 (e) because there were no reported allegations during the past 12 months.

Through interviews of the Director of Administration, he explained he would make residents aware of the outcome of investigations and the agency Zero Tolerance Policy requiring such notification it is determined that the facility meets the standard of this standard.

The facility meets the requirements of standard 115.373 (a-e)

Corrective Action Required: None

DISCIPLINE

Standard 115.376: Disciplinary sanctions for staff

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

115.376 (a)

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

115.376 (b)

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

115.376 (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

115.376 (d)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. Zero Tolerance Policy
b. Student Files (to determine if related disciplinary action was deserved resulting from incidents)
c. Staff Files (to determine if related disciplinary action was issued)

Interviews included:
a. Program Director / PREA Compliance Manager
b. Director of Personnel
c. Random Staff

Site Review / Observations:
a. N/A

115.376 (a) EDL's Zero Tolerance Policy (page 12, section 1, A) lists that staff members are subject to disciplinary sanctions up to and including termination of employment for violating EDL sexual abuse or sexual harassment policies.

115.376 (b) EDL's Zero Tolerance Policy (page 12, section 1, B) lists termination of employment is the presumptive disciplinary sanction for staff members who have engaged in sexual abuse. This is in accordance with this provision.

115.376 (c) EDL's Zero Tolerance Policy (page 12, section 1, C) is written in accordance with the provision of this PREA standard (115.373 c). It states, disciplinary sanctions for violations of EDL 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.

115.376 (d) EDL's Zero Tolerance Policy (page 12, section 1, d) relates to this provision of the standards. Specifically, the policy state that EDL reports the following actions to any relevant licensing bodies:

(1) Terminations of employment for violations of agency sexual abuse or sexual harassment policies; and
(2) Resignations by staff members who would have been terminated if they had not resigned.

During the on-site phase of the audit, both PREA auditors reviewed staff files, including disciplinary actions. Documents reviewed showed zero disciplinary actions for violating EDL's Zero Tolerance Policy. Director of Personnel Eric Payton reported zero terminations in the past 36 months for violations of the agency's Zero Tolerance Policy. Jim Stewart of the Brazos County Sheriff's Office was unaware of any reports of EDL staff being terminated for violating agency sexual abuse or sexual harassment policies.

The facility meets the requirements of standard 115.376 (a-d)

Corrective Action Required: None

Standard 115.377: Corrective action for contractors and volunteers

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

115.377 (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

115.377 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. Zero Tolerance Policy
b. Student Files (to determine if related disciplinary action was deserved resulting from incidents)
c. Staff Files (to determine if related disciplinary action was issued)

Interviews included:

a. Director of Administration

b. Program Director / PREA Compliance Manager
c. Director of Personnel

Site Review / Observations:
a. N/A

115.377(a) Included in EDL's Zero Tolerance Policy (page 12, section 2) is the language that contractors and volunteers engage in sexual abuse, EDL will:

(1) Prohibit the contractor or volunteer from having any contact with EDL youth; and
(2) Report the finding of abuse to any relevant licensing bodies.

During interviews with the Program Director and Director of Personnel, this auditor asked both staff members to explain what they would do if they received an allegation of sexual abuse or sexual harassment by a contractor or volunteer. Both the Program Director and Director of Personnel included calling law enforcement in their explanations.

115.377(b) Also included in EDL's Zero Tolerance Policy (page 12, section 2) is the language that states if a volunteer or contractor violates EDL sexual abuse or sexual harassment policies but does not actually engage in sexual abuse, EDL takes appropriate remedial measures and considers whether to prohibit further contact with EDL youth.

During his interview, Director of Personnel Payton explained any person, employee, contractor, or volunteer would be excluded from further contact with EDL residents. Such remedial measures would prohibit the chance of further abuse or harm.

EDL meets the standard 115.377 (a-b) because the EDL Zero Tolerance Policy includes the appropriate language, the interviews of the Program Director and Director of Personnel showed staff knowledge of the requirements, and there were no reported allegations of sexual abuse or sexual harassment by contractors or volunteers in the past 12 months.

The facility meets the requirements of standard 115.377 (a-b)

Corrective Action Required: None

Standard 115.378: Interventions and disciplinary sanctions for residents

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

115.378 (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, may residents be subject to disciplinary sanctions only pursuant to a formal disciplinary process?
  ☒ Yes ☐ No

115.378 (b)

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

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.378 (c)

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

115.378 (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 offer the offending resident participation in such interventions? ☒ Yes ☐ No

- If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education? ☒ Yes ☐ No

115.378 (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

115.378 (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

115.378 (g)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

d. Zero Tolerance Policy
e. Student Files
f. Staff Files

Interviews included:
d. Program Director / PREA Compliance Manager
e. Director of Personnel
f. Mental Health Staff

Site Review / Observations:
b. N/A

115.378 (a) EDL's Zero Tolerance Policy (page 12, section 3) states residents may be subject to disciplinary sanctions for engaging in sexual abuse only when:
(1) There is a criminal finding of guilt or an administrative finding that the youth engaged in youth on youth sexual abuse; and
(2) The discipline is determined through a Level II due process hearing.

115.378 (b & c) EDL's Zero Tolerance Policy (page 12, section 3) states disciplinary sanctions are commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories.

EDL does not utilize the use of isolation as a disciplinary sanction. This was confirmed in interviews of the Director of Administration and Program Director. Both staff (2 of 2) stated isolation is not used at EDL. As a result of not using isolation, residents would not miss required educational programming, special education services, medical or mental health care, and would have access to other programs and work opportunities.

In the last 12 months there were no allegations of sexual abuse or sexual harassment, therefore there were no reports or case files to review to determine non-compliance with this standard.

Director of Administration Payton explained in his interview that isolation is not used at EDL as sanctions for any policy violation including violating the facilities sexual abuse and sexual harassment Zero Tolerance Policy. In his explanation he explained any sanctions for rule violations are individualized (taking into consideration the residents' mental abilities and/or disabilities) and proportionate to the nature and circumstance of the rule violations committed.

115.378 (d) EDL's Zero Tolerance Policy (page 12, section 3) states the facility does offer youth abusers counseling and other interventions designed to address and correct underlying reasons or motivations for the abuse. EDL may require participation in such counseling and interventions as a condition of access to behavior-based incentives, but not as a condition to access general programming or education.

During his specialized staff interview (Mental Health Staff), Dr. Richard Toney confirmed EDL would offer therapy, counseling, or other intervention services to an offending student as well as the victim. He also explained that there would be no related access restrictions to the rewards-based behavior management systems, general program, or school.

115.378 (e) EDL's Zero Tolerance Policy (page 12, section 3, F) states a youth may be disciplined for sexual contact with staff only upon a finding that the staff member did not consent to such contact. During a review of the residents case files, auditors found no evidence of non-compliance with this standard.

115.378 (f) EDL's Zero Tolerance Policy (page 12, section 3, G) states EDL may not discipline a youth if the youth made a report of sexual abuse 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.

115.378 (g) EDL's Zero Tolerance Policy (page 12, section 3, H) states EDL may also discipline a youth for engaging in prohibited sexual activity that does not meet the definition of abuse. This policy statement is compliant with provision 115.378 (g).

EDL meets the standard 115.378 (a-g) because the EDL Zero Tolerance Policy includes the appropriate language, the interviews of the Program Director and Director of Personnel showed staff knowledge of the requirements, and resident case file audit revealed no reported allegations of sexual abuse or sexual harassment in the past 12 months.

The facility meets the requirements of standard 115.378 (a-g)

Corrective Action Required: None

MEDICAL AND MENTAL CARE

Standard 115.381: Medical and mental health screenings; history of sexual abuse

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

115.381 (a)

- If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (b)

- If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (c)

- Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law? ☒ Yes ☐ No

115.381 (d)

- Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. Zero Tolerance Policy
b. Resident Files
c. Staff Files

Interviews included:

a. Program Director / PREA Compliance Manager
b. Director of Personnel
c. Mental Health Staff
d. Intake Staff
e. Random Staff

Site Review / Observations:

a. N/A

115.381 (a) If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. EDL's Zero Tolerance policy states EDL offers all youth an appointment with a medical or mental health practioners within 30 days after the intake screening referral. This auditor recommends the EDL policy be updated to reflect 14 days instead of 30. When asked, during staff interviews, the protocol and timeline for follow up meetings following disclosure of sexual victimization the Director of Administration and 2 of 2 intake staff reported they would refer a youth immediately and the youth would be seen within 5 days by the on-site therapist. Auditors did not find through interviews or file audits that the facility was not in compliance, nor was an allegation of sexual victimization made in the past 36 months, therefore the facility was found to be in compliance with this standard.

115.381 (b) If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. Director of Administration and 2 of 2 intake staff said they would not change the referral process based on a resident's status as a victim or perpetrator.

Auditor reviewed resident case files, including intake screening and mental health documents, and found no evidence of non-compliance with this standard.

115.381 (c) The PAQ completed by Director of Administration Cedric Payton shows that any information shared with other staff is strictly limited to informing security and management decisions, including treatment plans, housing, bed, work, education, and program assignments, or as otherwise

required by federal, state, or local law. During the on-site facility tour, auditors Howell and Williams were able to look for and observe resident assignments and ask questions of staff and residents. No violations of standard 115.381 (c) were observed or discovered in the interview process.

115.381 (d) According to EDL's Zero Tolerance Policy (page 13, section M, 1), medical and mental health practioners must obtain informed consent from youth before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18.

During the interviews of the 2 mental health staff and the 2 intake screening staff it appeared 4 of the 4 staff understood the mandated child abuse reporting laws. 4 of 4 (100%) could explain the mandated reporting processes. Auditors found no evidence of an allegation in the past 12 months that would require a mandated sexual abuse report.

The facility meets the requirements of standard 115.381 (a-d)

Corrective Action Required: None

Standard 115.382: Access to emergency medical and mental health services

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

115.382 (a)

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

115.382 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362? ☒ Yes ☐ No

- Do staff first responders immediately notify the appropriate medical and mental health practitioners? ☒ Yes ☐ No

115.382 (c)

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

115.382 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. Zero Tolerance Policy
b. Resident Files
c. Staff Files

Interviews included:
a. Program Director / PREA Compliance Manager
b. Director of Personnel
c. Mental Health Staff
d. Intake Staff
e. Random Staff

Site Review / Observations:
a. N/A

115.382 (a) According to EDL's Zero Tolerance Policy, resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services by referral, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment.

There were no allegations or referrals related to sexual abuse or sexual harassment in the past 12 months. When the SANE nurse (Niki Johnson) at Baylor Scott & White Hospital was interviewed, she explained she had no secondary materials (logs, forms, etc..) available for review because there were

no allegations of sexual abuse in the past three years. She did explain the importance of timeliness of emergency medical treatment and crisis intervention services, the appropriate response by non-health staff in the event health staff are not present (note: EDL does not have health staff) at the time the incident is reported; and the provision of appropriate and timely information and services concerning contraception and sexually transmitted infection prophylaxis.

115.382 (b) If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, staff first responders take preliminary steps to protect the victim pursuant to § 115.362. This was confirmed in the staff interviews. 12 of 12 (100%) of the random staff interviewed could explain the preliminary steps to protect the victim of sexual abuse. 12 of 12 staff also stated they would, upon learning of an allegation or incident, immediately notify the appropriate medical and mental health practitioners.

115.382(c) EDL's Zero Tolerance Policy states that resident victims of sexual abuse offered timely information about and timely access to medical care in accordance with professionally accepted standards of care, where medically appropriate. The Program Director, in his interview, explained in the event of an incident that was sexual in nature, residents would be immediately transported to the hospital for medical services and offered appropriate and timely information and services concerning contraception and sexually transmitted infection prophylaxis. He also reported that there were zero allegations of sexual abuse and zero allegations of sexual harassment in the past 12 months. There were no residents who reported abuse, therefore auditors could not ask residents who had reported abuse what information they received or what treatment they were offered after what happened to them.

115.382 (d) EDL's Zero Tolerance Policy states EDL provides treatment services to the victim without cost and regardless of whether the victim names the abuser or cooperates with any investigation arising from the incident. The Baylor Scott & White SANE Nurse also explained the forensic medical services are provided without cost.

Based on the information received through staff interviews, facility tours, and file reviews the facility was in compliance with standard 115.382 (a-d).

The facility meets the requirements of standard 115.382 (a-d)

Corrective Action Required: None

Standard 115.383: 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

115.383 (a)

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

115.383 (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

115.383 (c)

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

115.383 (d)

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

115.383 (e)

- If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if "all-male" facility. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☐ Yes ☐ No ☐ NA

115.383 (f)

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

115.383 (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

115.383 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. Zero Tolerance Policy
b. Resident Files

Interviews included:
a. Program Director / PREA Compliance Manager
b. Medical and Mental Health Staff
c. Intake Staff
d. Random Staff
e. Residents that reported sexual abuse (N/A)

Site Review / Observations:
b. N/A

115.383(a) Included in EDL's Zero Tolerance Policy (page 13, section 3, A) is a procedure for a sexual abuse victim and/or perpetrator to be offered a 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. Observations while on the facility tour included posters and brochures that residents could easily access. Information available included toll free, anonymous, and confidential phone numbers included:

a. SARC (979) 731-1000
b. Scotty's House Brazos Valley Child Advocacy Center (979) 703-8813
c. Foster Care Ombudsman (844) 286-0769

115.383(b) 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. The EDL Zero Tolerance Policy (page 13, section 3, C) confirms this statement. SARC and Scotty's House provide follow up services to residents and advice to facility administrators as needed. Because there were no reports of sexual abuse or

sexual harassment, auditors were unable to interview any residents that had made a report and may need follow up services, etc.

115.383(c) EDL's Zero Tolerance Policy (page 13, section 3, A) states that EDL provides such victims with medical and mental health services consistent with the community level of care. When interviewed the contracted Therapist stated the medical and mental health services are consistent with the community level of care. The Director of Administration / PREA Coordinator explained that the medical and mental health services are consistent with the community level of care because they are with the same community providers as anyone else. He mentioned two providers as SARC and Scotty's House. Auditor Howell was provided a memorandum of understanding between EDL and Scotty's House. The MOU addresses a team approach to both agencies working together on child abuse and neglect. The document was signed and dated 08/24/19.

115.383(d,e,f) Resident victims of sexually abusive vaginal penetration while incarcerated are offered pregnancy tests. This auditor acknowledges the facility is all male, however in the event of the presence of a transgender male (with female genitals) a pregnancy test would be appropriate following abusive vaginal penetration. The SANE nurse at Baylor Scott & White confirmed that offering pregnancy test, providing timely and comprehensive information about and to all lawful pregnancy related medical services, and testing for sexually transmitted infections was part of the protocol used.

115.383(g) According to EDL's Zero Tolerance Policy, EDL provides treatment services to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising from the incident. There were zero reported incidents of sexual abuse, therefore there were no residents to ask or records to review to determine non-compliance with this standard.

115.383(h) EDL attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners. The EDL Zero Tolerance Policy states that when EDL learns of abuse history they refer the resident to mental health practioners within 30 days. Dr. Richard Toney was interviewed and confirmed the mental health staff do conduct mental health evaluations and offer treatment upon learning of such abuse history.

Based on the information received through staff interviews, interviews with medical and mental health staff, facility tours, and file reviews the facility was in compliance with standard 115.383 (a-h).

The facility meets the requirements of standard 115.383 (a-h)

Corrective Action Required: None

DATA COLLECTION AND REVIEW

Standard 115.386: Sexual abuse incident reviews

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

115.386 (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

115.386 (b)

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

115.386 (c)

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

115.386 (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 §§ 115.386(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.386 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Documents reviewed included:

a. Zero Tolerance Policy
b. Resident Files

Interviews included:
a. Program Director / PREA Compliance Manager
b. Director of Administration
c. Brazos County Sheriff's Office
d. Incident Review Team

Observations included:
a. None

115.386(a,b) In accordance with EDL's Zero Tolerance Policy (page 14 section n), EDL 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. The Program Director reported all incidents and allegations that include an investigation are not concluded until an investigation is conducted. He reported that such a review would occur within 30 days of the conclusion of the investigation. There were no reported allegations or investigations of sexual abuse in the past 12 months. There were no investigation documents to review to determine non-compliance.

115.386(c) The EDL incident review team includes upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners. The EDL team consists of the following individuals:

a. Director of Administration / PREA Coordinator
b. Program Director / PREA Manager
c. Investigating agency representative (Sherriff or TDFPS)
d. SANE Nurse from forensic examination facility

Interviews of the Chief Deputy of the Sheriff's Investigations Division and the SANE nurse at Baylor Scott & White hospital confirmed they would participate in any post investigation review.

There were zero allegations and investigations of sexual abuse in the past 12 months.

115.386(d) Interviews of the he review team indicated that they:

- Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse.
- 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.
- Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse.
- Assess the adequacy of staffing levels in that area during different shifts.
- Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff.
- Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager.

There were no investigations during the past 36 months, therefore there were no review team meeting minutes for auditors to review.

115.386(e) Per EDL Zero Tolerance Policy (page 14, section n, 4) EDL would implement the recommendations for improvement, or document its reasons for not doing so. There were no investigations or reported incidents, therefore there were no recommendations for improvement.

Based on the information received through staff interviews, interviews with review team members, facility tours, and file reviews the facility was in compliance with standard 115.386 (a-e).

The facility meets the requirements of standard 115.386 (a-e)

Corrective Action Required: None

Standard 115.387: Data collection

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

115.387 (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

115.387 (b)

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

115.387 (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

115.387 (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

115.387 (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

115.387 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Documents reviewed included:

a. Zero Tolerance Policy
b. Memo regarding data collection

Interviews included:

a. Program Director / PREA Compliance Manager
b. Director of Administration

Observations included:

a. Agency web site (www.everydaylifertc.com)

115.387(a-f) EDL's Zero Tolerance Policy (page 14, section o) states that EDL collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. EDL did not provide evidence of participating in the most recent version of the Survey of Sexual Violence conducted by the DOJ. EDL's Director of Administration reported that they would review, collect, aggregate and report all data if EDL had any allegations of sexual abuse or sexual harassment. He acknowledged such a review and report should be done at lest annually. EDL does maintain records and collect data as needed from all incident-based documents related to all incidents. There were no allegations or incidents related to sexual abuse or harassment in the past 12 months. The EDL Zero Tolerance Policy states that it EDL obtains incident-based and aggregate data from each residential facility operating under a contract with EDL. At the time of the audit and during the past 12 months there were no facilities operating under a contract with EDL. The Director of Administration acknowledged in his interview that upon request, EDL shall provide all such data from the previous calendar year to the Department of Justice no later than June 30. Note: EDL reported to this auditor that DOJ has not requested EDL data.

Based on the information received through staff interviews, interviews with review team members, facility tours, and file reviews the facility was in compliance with standard 115.387 (a-f).

The facility meets the requirements of standard 115.387 (a-f)

Corrective Action Required: None

Standard 115.388: Data review for corrective action

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

115.388 (a)

- Does the agency review data collected and aggregated pursuant to § 115.387 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 § 115.387 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 § 115.387 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

115.388 (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

115.388 (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

115.388 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in the making the compliance decision:

Documents reviewed included:

a. Everyday Life Zero Tolerance Policy

Interviews included:
a. Program Director / PREA Coordinator
b. Chief Executive Officer

Site Review / Observations:
b. Agency web page

115.388
The agency PREA Coordinator, when interviewed, explained that he is prepared to review data collected and aggregated pursuant to § 115.387 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. Fortunately, there have been no allegations of sexual abuse or harassment in the past 36 months. In other words, there is no data to aggregate and compare.

Again, the agency has no data collect, review, and aggregated pursuant to § 115.387 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.

EDL did not review data that was collected and aggregated pursuant to § 115.387 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. Auditors discussed having the Chief Executive Officer write a memo that explains there was not data reported due to there being no allegations or incidents of sexual abuse or harassment. The memo could serve as documented proof that the expectations of 114.388 are being met.

115.388 (b)
EDL did not complete an annual report because there were no allegations of sexual abuse or harassment. If there was data, the Program Director / PREA Coordinator stated EDL would have an annual report that included 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.

115.388 (c)
EDL did not complete an annual report because there were no allegations of sexual abuse or harassment. If there was data, the Program Director / PREA Coordinator stated EDL would have an

annual report approved by the agency head and made readily available to the public through its website.

115.388 (d)
EDL did not complete an annual report because there were no allegations of sexual abuse or harassment. If there was data, the Program Director / PREA Coordinator stated EDL would have an annual report and would 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.

During the on-site phase of the PREA audit this auditor concluded the facility was not preparing a report annually or providing a report to the public. On August 28, 2019 Director of Administration / PREA Coordinator Cedric Payton provided a memorandum stating EDL had no allegations of sexual abuse or sexual harassment, therefore they had not gathered any statistics to report on the EDL website. Further, EDL was aware of the need to update this information on the web site.

The facility did not initially meet the requirements of standard 115.388 (c), however corrective action was completed before the Final Report was written. See below.

Corrective Action Required:

The Director of Administration must post on the agency web page a memo that states in the place of an annual report that compares aggregated incident data, the memo shall serve as notice that EDL had zero allegations or investigations related to sexual abuse or harassment during the past 12 months. The maximum timeline to accomplish the corrective action and show proof is 180 days from EDL receiving the Interim PREA Audit Report.

On Sunday February 9, 2020 auditor Lawrence Howell confirmed the corrective action was completed on the new and improved EDL website. The facility web pages states, “Everyday Life had zero allegations or investigations related to sexual abuse or harassment during the past 12 months. (August 2018-2019).” www.edlrtc.com

Standard 115.389: Data storage, publication, and destruction

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

115.389 (a)

- Does the agency ensure that data collected pursuant to § 115.387 are securely retained? ☒ Yes ☐ No

115.389 (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

115.389 (c)

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

115.389 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Documents reviewed included:

a. Everyday Life Zero Tolerance Policy

Interviews included:
a. Program Director / PREA Coordinator
b. Director of Administration

Site Review / Observations:
a. Agency web page: www.edlrtc.com

115.389(a) EDL's Zero Tolerance Policy states that the agency collects and retains sexual abuse and sexual harassment data in a secure manner. This information was located on page14, section O, line 4.

115.389(b) EDL's Zero Tolerance Policy (page 14, section p) states EDL makes 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. A report was not posted for the past 12 months. EDL did not complete an annual report because there were no allegations of sexual abuse or harassment. If there was data, the Program Director / PREA Coordinator and Director of Administration

stated EDL would have an annual report approved by the agency head and made readily available to the public through its website.

115.389(c) Due to there not being any data to aggregate, the issue of completing an annual aggregated sexual abuse report was discussed with the EDL Director of Administration and Program Director. Both individuals acknowledged that future reports will have all personal identifiers removed before making aggregated sexual abuse data publicly available.

115.389(d) EDL's document storage policy is to maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise.

The facility did not initially meet the requirements of standard 115.389 (b), however corrective action was taken before the Final Report was completed. See below.

Corrective Action Required:

The Director of Administration must post on the agency web page a memo that states in the place of an annual report that compares aggregated incident data, the memo shall serve as notice that EDL had zero allegations or investigations related to sexual abuse or harassment during the past 12 months. The maximum timeline to accomplish the corrective action and show proof is 180 days from EDL receiving the Interim PREA Audit Report.

On Sunday February 9, 2020 auditor Lawrence Howell confirmed the corrective action was completed on the new and improved EDL website. The facility web pages states, "Everyday Life had zero allegations or investigations related to sexual abuse or harassment during the past 12 months. (August 2018-2019)." www.edlrtc.com

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

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

115.401 (a)

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

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard*.) ☐ Yes ☒ No

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

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

115.401 (h)

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

115.401 (i)

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

115.401 (m)

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

115.401 (n)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

The facility was in compliance with standard 115.401 as a result of the following:

- Both auditors Lawrence Howell and Jerome Williams had complete access to every area of the facility.
- Lead auditor Howell was permitted to request and receive copies of any relevant documents.
- Both Howell and Williams were permitted to conduct private interviews of residents and staff.
- A copy of the upcoming audit, with auditor Howell's personal contact information was posted allowing residents to send confidential information or correspondence in the same manner as if they were communicating with legal counsel. No correspondence was received.

Corrective Action Required: None

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

115.403(f) Everyday Life Residential Treatment Center was audited in 2016. The dates of the facility visit were May 25, 26, 27, 2016. A Final PREA Audit Report was issued by certified PREA Auditor Jerome Williams on December 21, 2016. The 2016 report is posted on the EDL website.

The facility meets the requirements of standard 115.403 (f).

Corrective Action Required: None

AUDITOR CERTIFICATION

I certify that:

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

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

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

Auditor Instructions:

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

Lawrence Howell October 22, 2019

Auditor Signature **Date**

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

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