Prison Rape Elimination Act (PREA) Audit Report
Juvenile Facilities

☐ **Interim** ☒ **Final**

Date of Interim Audit Report: October 11th, 2021 ☐ **N/A**

If no Interim Audit Report, select N/A

Date of Final Audit Report: April 4th, 2022

Auditor Information

Name: Jerome K. Williams	**Email:** wjerome27@yahoo.com
Company Name: N/A	
Mailing Address: 749 Rutherford Dr	**City, State, Zip:** Crowley, Texas 76036
Telephone: 512-636-8137	**Date of Facility Visit:** August 25th-27th, 2021

Agency Information

Name of Agency: L.L. Brandon III Transitional Home for Boys			
Governing Authority or Parent Agency *(If Applicable):* Northwest Louisiana Community Development Corporation			
Address: 4725 Greenwood Rd		**City, State, Zip:** Shreveport, LA 71109	
Mailing Address: Same as above		**City, State, Zip:** Click or tap here to enter text.	
The Agency Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal
Agency Website with PREA Information: www.info@northwestlouisianacdcorg.			

Agency Chief Executive Officer

Name: Larry Lawrence Brandon, Executive Director	
Email: LLawrenceBrandon@gmail.com	**Telephone:** 318-631-3449

Agency-Wide Administrative Assistant/PREA Coordinator

Name: Wenona Milus, Administrative Assistant	
Email: Brandonhouse318@gmail.com	**Telephone:** 318-631-3449
Administrative Assistant/PREA Coordinator Reports to:	**Number of Compliance Managers who report to the Administrative Assistant/PREA Coordinator:**

Executive Director	0

Facility Information

Name of Facility: L.L. Brandon III Transitional Home for Boys			
Physical Address: 1 Westwood Circle		**City, State, Zip:** Shreveport, LA 71109	
Mailing Address: Same as above		**City, State, Zip:** Click or tap here to enter text.	
The Facility Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

Facility Website with PREA Information: www.info@northwestlouisianacdc.orginfor@northwestlouisianacdc.org

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

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

☐ ACA

☐ NCCHC

☐ CALEA

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

☒ N/A

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

Facility Administrator/Superintendent/Director

Name:	Larry Lawrence Brandon, Executive Director		
Email:	Brandonhouse318@gmail.com	**Telephone:**	318-631-3449

Facility PREA Compliance Manager

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

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:	34
Current Population of Facility:	20
Average daily population for the past 12 months:	18
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:	16 to 21 years of age
Average length of stay or time under supervision	6 months
Facility security levels/resident custody levels	Non-secure, minimum

Number of residents admitted to facility during the past 12 months	90
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:	90
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *10 days or more:*	90
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: Louisiana Dept of Children and Family Services (DCFS ☐ N/A

Number of staff currently employed by the facility who may have contact with residents:	40
Number of staff hired by the facility during the past 12 months who may have contact with residents:	23
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	1

Number of individual contractors who have contact with residents, currently authorized to enter the facility:	1
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.**	1
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.**	4
Number of single resident cells, rooms, or other enclosures:	38
Number of multiple occupancy cells, rooms, or other enclosures:	2
Number of open bay/dorm housing units:	0
Number of segregation or isolation cells or rooms (for example, administrative, disciplinary, protective custody, etc.):	0
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: ☐ 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: Louisiana Office of Juvenile Justice) ☐ N/A

Post-Audit Reporting Information

General Audit Information	
Onsite Audit Dates	
1. Start date of the onsite portion of the audit:	8/25/2021
2. End date of the onsite portion of the audit:	8/27/2021
Outreach	
3. Did you attempt to communicate with community-based organization(s) or victim advocates who provide services to this facility and/or who may have insight into relevant conditions in the facility?	☒ Yes ☐ No
a. If yes, identify the community-based organizations or victim advocates with whom you corresponded:	Project Celebration
Audited Facility Information	
4. Designated Facility Capacity:	34
5. Average daily population for the past 12 months:	18
6. Number of inmate/resident/detainee 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 inmates 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.	4
7. Does the facility ever hold youthful inmates or youthful/juvenile detainees?	☐ Yes ☐ No

	☒ N/A for the facility type audited (i.e., Community Confinement Facility or Juvenile Facility)
Audited Facility Population on Day One of the Onsite Portion of the Audit	
Inmates/Residents/Detainees	
8. Enter the total number of inmates/residents/detainees housed at the facility as of the first day of the onsite portion of the audit:	20
9. Enter the total number of youthful inmates or youthful/juvenile detainees housed at the facility on the first day of the onsite portion of the audit:	0
10. Enter the total number of inmates/residents/detainees with a physical disability housed at the facility as of the first day of the onsite portion of the audit:	0
11. Enter the total number of inmates/residents/detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) housed at the facility as of the first day of the onsite portion of the audit:	0
12. Enter the total number of inmates/residents/detainees who are Blind or have low vision (visually impaired) housed at the facility on the first day of the onsite portion of the audit:	0
13. Enter the total number of inmates/residents/detainees who are Deaf or hard-of-hearing housed at the facility on the first day of the onsite portion of the audit:	0
14. Enter the total number of inmates/residents/detainees who are Limited English Proficient (LEP) housed at the facility as of the first day of the onsite portion of the audit:	0
15. Enter the total number of inmates/residents/detainees who identify as lesbian, gay, or bisexual housed at the facility as of the first day of the onsite portion of the audit:	0
16. Enter the total number of inmates/residents/detainees who identify as transgender, or intersex housed at the facility as of the first day of the onsite portion of the audit:	0
17. Enter the total number of inmates/residents/detainees who reported sexual abuse in this facility who are housed at the facility as of the first day of the onsite portion of the audit:	0
18. Enter the total number of inmates/residents/detainees who reported sexual harassment in this facility who are housed at the facility as of the first day of the onsite portion of the audit:	0
19. Enter the total number of inmates/residents/detainees who disclosed prior sexual victimization during risk screening housed at the facility as of the first day of the onsite portion of the audit:	0
20. Enter the total number of inmates/residents/detainees who are or were ever placed in segregated housing/isolation for risk of sexual victimization housed at the facility as of the first day of the onsite portion of the audit:	0
21. Enter the total number of inmates/residents/detainees who are or were ever placed in segregated housing/isolation for having reported sexual abuse in	0

this facility as of the first day of the onsite portion of the audit:	

22. Enter the total number of inmates/residents detained solely for civil immigration purposes housed at the facility as of the first day of the onsite portion of the audit:	0
23. Provide any additional comments regarding the population characteristics of inmates/residents/detainees in the facility as of the first day of the onsite portion of the audit (e.g., groups not tracked, issues with identifying certain populations). *Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.*	As of the first day of the audit, the characteristics of this facility is that it is an all-male transitional facility where you can go home on the weekends, go to school and work, then eventually transition to their home. The population consisted of child welfare and juvenile justice youths who either diverted to this program and or were released on probation to this facility as a diversion to incarceration. There were no issues with identifying certain population required for interviewing.
Staff, Volunteers, and Contractors *Include all full- and part-time staff employed by the facility, regardless of their level of contact with inmates/residents/detainees*	
24. Enter the total number of STAFF, including both full- and part-time staff employed by the facility as of the first day of the onsite portion of the audit:	50
25. Enter the total number of CONTRACTORS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	1
26. Enter the total number of VOLUNTEERS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	0
27. Provide any additional comments regarding the population characteristics of staff, volunteers, and contractors who were in the facility as of the first day of the onsite portion of the audit. *Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.*	The facility currently does not employ volunteers or contractors who would have contact with the inmates/resident therefore no listing of such was provide for interviewing during the pre-audit phase. The population characteristic of the staff was male, female, between the ages of 23 to 68, new hires; tenured staff, and represented 3 of the 5 ethnic groups.
Interviews	
Inmate/Resident/Detainee Interviews	
Random Inmate/Resident/Detainee Interviews	
28. Enter the total number of RANDOM INMATES/RESIDENTS/DETAINEES who were interviewed:	12
29. Select which characteristics you considered when you selected random inmate/resident/detainee interviewees:	☒ Age ☒ Race ☒ Ethnicity (e.g., Hispanic, Non-Hispanic)

	☒ Length of time in the facility ☒ Housing assignment ☐ Gender ☐ Other (describe) Click or tap here to enter text. ☐ None (explain) Click or tap here to enter text.
30. How did you ensure your sample of random inmate/resident/detainee interviewees was geographically diverse?	Based on the population census provided during the pre-audit phase, this auditor selected residents of different ages, housing assignment, child welfare, probation placement assignment, and whether they were allowed to leave the facility for school, work or weekend visits with family. They were all of the same ethnicity
31. Were you able to conduct the minimum number of random inmate/resident/detainee interviews?	☒ Yes ☐ No
a. If no, explain why it was not possible to interview the minimum number of random inmate/resident/detainee interviews:	Click or tap here to enter text.
32. Provide any additional comments regarding selecting or interviewing random inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation, etc.). *Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.*	The process utilized to select random resident from the population census listing for interviewing during the pre-audit phase was that every odd numbered resident on the census listing was selected for interviewing. When one resident selected was not available during the onsite visit (e.g., released) then an even number resident was randomly selected for the interview by this auditor.
Targeted Inmate/Resident/Detainee Interviews	
33. Enter the total number of TARGETED INMATES/RESIDENTS/DETAINEES who were interviewed: *As stated in the PREA Auditor Handbook, the breakdown of targeted interviews is intended to guide auditors in interviewing the appropriate cross-section of inmates/residents/detainees who are the most vulnerable to sexual abuse and sexual harassment. When completing questions regarding targeted inmate/resident/detainee interviews below, remember that an interview with one inmate/resident/detainee may satisfy multiple targeted interview requirements. These questions are asking about the number of interviews conducted using the targeted inmate/resident/detainee protocols.* *For example, if an auditor interviews an inmate who has a physical disability, is being held in segregated housing due to risk of sexual victimization, and disclosed prior sexual victimization, that interview would be included in the totals for each of those questions. Therefore, in most cases, the sum of all the following responses to the targeted*	0

inmate/resident/detainee interview categories will exceed the total number of targeted inmates/residents/detainees who were interviewed. *If a particular targeted population is not applicable in the audited facility, enter "0".*	
34. Enter the total number of interviews conducted with youthful inmates or youthful/juvenile detainees using the "Youthful Inmates" protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	This auditor reviewed the submitted PAQ, resident files, intake records and ascertained from the interviews with the staff and residents that this is a juvenile facility and the term "youthful inmates" is not applicable since their entire population is juvenile. This is a juvenile residential facility.
35. Enter the total number of interviews conducted with inmates/residents/detainees with a physical disability using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	This auditor reviewed the submitted PAQ, resident files, intake records and ascertained from the interviews with the staff and residents that there were no residents with a physical disability in their population currently or in the last 12 months Therefore, no targeted interview protocol was utilized.
36. Enter the total number of interviews conducted with inmates/residents/detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) using the "Disabled and Limited English Proficient Inmates" protocol:	0

a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	This auditor reviewed the submitted PAQ, resident files, intake records and ascertained from interviews with the staff and residents that there were no residents with a cognitive or functional disability in their population currently or in the last 12 months. Therefore, no targeted interview protocol was utilized.
37. Enter the total number of interviews conducted with inmates/residents/detainees who are Blind or have low vision (visually impaired) using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	This auditor reviewed the submitted PAQ, resident files, intake records and ascertained from interviews with the staff and residents that there were no residents that was Blind or have low vision in their population currently or in the last 12 months. Therefore, no targeted interview protocol was utilized.
38. Enter the total number of interviews conducted with inmates/residents/detainees who are Deaf or hard-of-hearing using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	This auditor reviewed the submitted PAQ, resident files, intake records and ascertained from interviews with the staff and residents that there were no residents Deaf or hard of hearing in their population currently or in the last 12 months. Therefore, no targeted interview protocol was utilized.

39. Enter the total number of interviews conducted with inmates/residents/detainees who are Limited English Proficient (LEP) using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	This auditor reviewed the submitted PAQ, resident files, intake records and ascertained from interviews with the staff and residents that there were no residents who identified as Limited in English Proficiency (LEP) in their population currently or in the last 12 months. Therefore, no targeted interview protocol was utilized.
40. Enter the total number of interviews conducted with inmates/residents/detainees who identify as lesbian, gay, or bisexual using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	This auditor reviewed the submitted PAQ, resident files, intake records and ascertained from interviews with the staff and residents that there were no residents who identified as lesbian, gay or bisexual in their population currently or in the last 12 months. Therefore, no targeted interview protocol was utilized.
41. Enter the total number of interviews conducted with inmates/residents/detainees who identify as transgender or intersex "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	This auditor reviewed the submitted PAQ, resident files, intake records and ascertained from interviews with the staff and residents that there were no residents who identified as Transgender or Intersex in their population

	currently or in the last 12 months. Therefore, no targeted interview protocol was utilized.
42. Enter the total number of interviews conducted with inmates/residents/detainees who reported sexual abuse in this facility using the "Inmates who Reported a Sexual Abuse" protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	This auditor reviewed the submitted PAQ, resident files, intake records and ascertained from interviews with the staff and residents that there were no residents in their population currently or in the last 12 months who reported a sexual abuse. Therefore, no targeted interview protocol was utilized
43. Enter the total number of interviews conducted with inmates/residents/detainees who disclosed prior sexual victimization during risk screening using the "Inmates who Disclosed Sexual Victimization during Risk Screening" protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	This auditor reviewed the submitted PAQ, resident files, intake records and ascertained from interviews with the staff and residents that there were no residents in their population currently or in the last 12 months who disclosed sexual victimization during the Risk Assessment Screening protocol. Therefore, no targeted interview protocol was utilized.
44. Enter the total number of interviews conducted with inmates/residents/detainees who are or were ever placed in segregated housing/isolation for risk of sexual victimization using the "Inmates Placed in Segregated Housing (for Risk of Sexual Victimization/Who Alleged to have Suffered Sexual Abuse)" protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	This auditor reviewed the submitted PAQ, resident files, intake records and ascertained from interviews with the staff and residents that there were no residents in their population currently or in the last 12 months who were placed in Segregated Housing who either alleged or suffered from Sexual Abuse. This is a transitional juvenile residential facility and it is not designed for nor do they place residents in segregated housing. Therefore, no targeted interview protocol was utilized.
45. Provide any additional comments regarding selecting or interviewing random inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation, etc.). *Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.*	Since the required number of targeted residents were not in their population during the onsite audit, this auditor interviewed additional random resident to meet the required PREA standards for the number of random residents to interview for a community confinement facility.
Staff, Volunteer, and Contractor Interviews	
Random Staff Interviews	
46. Enter the total number of RANDOM STAFF who were interviewed:	12
47. Select which characteristics you considered when you selected RANDOM STAFF interviewees (select all that apply):	☒ Length of tenure in the facility ☒ Shift assignment ☒ Work assignment ☒ Rank (or equivalent) ☒ Other (describe) Gender (male and female) ☐ None (explain) Click or tap here to enter text.
48. Were you able to conduct the minimum number of RANDOM STAFF interviews?	☒ Yes ☐ No
a. If no, select the reasons why you were not able to conduct the minimum number of RANDOM STAFF interviews (select all that apply):	☐ Too many staff declined to participate in interviews ☐ Not enough staff employed by the facility to meet the minimum number of random staff interviews (Note: select this option if there were not enough staff employed by the facility or not enough staff employed by the facility to interview for both random and specialized staff roles). ☐ Not enough staff available in the facility during the onsite portion of the audit to meet the minimum number of random staff interviews. ☐ Other (describe) Click or tap here to enter text.
b. Describe the steps you took to select additional RANDOM STAFF interviewees and why you were still unable to meet the minimum number of random staff interviews:	

49. Provide any additional comments regarding selecting or interviewing random staff (e.g., any populations you oversampled, barriers to completing interviews, etc.). *Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.*	There were no barriers encountered during the onsite visit or during the interviews of the random staff.
Specialized Staff, Volunteers, and Contractor Interviews *Staff in some facilities may be responsible for more than one of the specialized staff duties. Therefore, more than one interview protocol may apply to an interview with a single staff member and that interview would satisfy multiple specialized staff interview requirements.*	
50. Enter the total number of staff in a SPECIALIZED STAFF role who were interviewed (excluding volunteers and contractors):	12
51. Were you able to interview the Agency Head?	☒ Yes ☐ No
a. If no, explain why it was not possible to interview the Agency Head:	Click or tap here to enter text.
52. Were you able to interview the Warden/Facility Director/Superintendent or their designee?	☒ Yes ☐ No
a. If no, explain why it was not possible to interview the Warden/Facility Director/Superintendent or their designee:	Click or tap here to enter text.
53. Were you able to interview the PREA Coordinator?	☒ Yes ☐ No
a. If no, explain why it was not possible to interview the PREA Coordinator:	Click or tap here to enter text.
54. Were you able to interview the PREA Compliance Manager?	☐ Yes ☐ No ☒ N/A (N/A if the agency is a single facility agency or is otherwise not required to have a PREA Compliance Manager per the Standards)
a. If no, explain why it was not possible to interview the PREA Compliance Manager:	
5. Select which SPECIALIZED STAFF roles were interviewed as part of this audit (select all that apply):	☒ Agency contract administrator ☒ Intermediate or higher-level facility staff responsible for conducting and documenting unannounced rounds to identify and deter staff sexual abuse and sexual harassment ☐ Line staff who supervise youthful inmates (if applicable) ☐ Education and program staff who work with youthful inmates (if applicable) ☐ Medical staff ☐ Mental health staff ☒ Non-medical staff involved in cross-gender strip or visual searches ☒ Administrative (human resources) staff ☒ Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) staff ☐ Investigative staff responsible for conducting administrative investigations

	☐ Investigative staff responsible for conducting criminal investigations ☒ Staff who perform screening for risk of victimization and abusiveness ☐ Staff who supervise inmates in segregated housing/residents in isolation ☐ Staff on the sexual abuse incident review team ☒ Designated staff member charged with monitoring retaliation ☒ First responders, both security and non-security staff ☒ Intake staff ☐ Other (describe) Click or tap here to enter text.
56. Did you interview VOLUNTEERS who may have contact with inmates/residents/detainees in this facility?	☐ Yes ☒ No
a. Enter the total number of VOLUNTEERS who were interviewed:	0
b. Select which specialized VOLUNTEER role(s) were interviewed as part of this audit (select all that apply):	☐ Education/programming ☐ Medical/dental ☐ Mental health/counseling ☐ Religious ☐ Other
57. Did you interview CONTRACTORS who may have contact with inmates/residents/detainees in this facility?	☒ Yes ☐ No
a. Enter the total number of CONTRACTORS who were interviewed:	Click or tap here to enter text.
b. Select which specialized CONTRACTOR role(s) were interviewed as part of this audit (select all that apply):	☐ Security/detention ☐ Education/programming ☒ Medical/dental ☐ Food service ☐ Maintenance/construction ☐ Other
58. Provide any additional comments regarding selecting or interviewing specialized staff (e.g., any populations you oversampled, barriers to completing interviews, etc.). *Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.*	The part-time medical staff interviewed in this facility stated that her primary responsibility is only to ensure that the resident's medication is administered daily and if there are any other medical issues are prevalent e.g., feeling ill, cold, sprains, etc., that the resident be referred to the local hospital for an emergency room (ER) visit.

Site Review and Documentation Sampling

Site Review

PREA Standard 115.401(h) states, "The auditor shall have access to, and shall observe, all areas of the audited facilities." In order to meet the requirements in this Standard, the site review portion of the onsite audit must include a thorough examination of the entire facility. The site review is not a casual tour of the facility. It is an active, inquiring process that includes talking with staff and inmates to determine whether, and the extent to which, the audited facility's practices demonstrate compliance with the Standards. Note: discussions related to testing critical functions are expected to be included in the relevant Standard-specific overall determination narratives.	
59. Did you have access to all areas of the facility?	☒ Yes ☐ No
a. If no, explain what areas of the facility you were unable to access and why.	Click or tap here to enter text.
Was the site review an active, inquiring process that included the following:	
60. Reviewing/examining all areas of the facility in accordance with the site review component of the audit instrument?	☒ Yes ☐ No
a. If no, explain why the site review did not include reviewing/examining all areas of the facility.	Click or tap here to enter text.
61. Testing and/or observing all critical functions in the facility in accordance with the site review component of the audit instrument (e.g., intake process, risk screening process, PREA education)?	☒ Yes ☐ No
a. If no, explain why the site review did not include testing and/or observing all critical functions in the facility.	Click or tap here to enter text.
62. Informal conversations with inmates/residents/detainees during the site review (encouraged, not required)?	☒ Yes ☐ No
63. Informal conversations with staff during the site review (encouraged, not required)?	☒ Yes ☐ No
64. Provide any additional comments regarding the site review (e.g., access to areas in the facility, observations, tests of critical functions, or informal conversations). *Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.*	During the site review, there were no barriers encountered by this auditor regarding having total facility access, ability to observe and test critical functions or when engaging staff and residents in informal conversations.
Documentation Sampling	
Where there is a collection of records to review—such as staff, contractor, and volunteer training records; background check records; supervisory rounds logs; risk screening and intake processing records; inmate education records; medical files; and investigative files—auditors must self-select for review a representative sample of each type of record.	
65. In addition to the proof documentation selected by the agency or facility and provided to you, did you also conduct an auditor-selected sampling of documentation?	☒ Yes ☐ No

66. Provide any additional comments regarding selecting additional documentation (e.g., any documentation you oversampled, barriers to selecting additional documentation, etc.). *Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.*	During the site review, this auditor did request copies of completed as well as blank documents i.e., risk screening, forms and memorandums for triangulation purposes as oversamples.

Sexual Abuse and Sexual Harassment Allegations and Investigations in this Facility

Sexual Abuse and Sexual Harassment Allegations and Investigations Overview

Remember the number of allegations should be based on a review of all sources of allegations (e.g., hotline, third-party, grievances) and should not be based solely on the number of investigations conducted.
Note: For question brevity, we use the term "inmate" in the following questions. Auditors should provide information on inmate, resident, or detainee sexual abuse allegations and investigations, as applicable to the facility type being audited.

67. Total number of SEXUAL ABUSE allegations and investigations overview during the 12 months preceding the audit, by incident type:

Instructions: If you are unable to provide information for one or more of the fields below, enter an "X" in the field(s) where information cannot be provided.

	# of sexual abuse allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual abuse	0	0	0	0
Staff-on-inmate sexual abuse	0	0	0	0
Total	0	0	0	0

a. If you were unable to provide any of the information above, explain why this information could not be provided.	This auditor reviewed the submitted PAQ, resident records, and interview staff and residents onsite to ascertain if there were any sexual abuse allegations made and/or investigations occurred during the 12 months preceding the audit by incident type. The facility reported zero sexual abuse allegations and investigations and my triangulation during the above review corroborated this assessment

68. Total number of SEXUAL HARASSMENT allegations and investigations overview during the 12 months preceding the audit, by incident type:

Instructions: If you are unable to provide information for one or more of the fields below, enter an "X" in the field(s) where information cannot be provided.

	# of sexual harassment allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual harassment	0	0	0	0
Staff-on-inmate sexual harassment	0	0	0	0
Total	0	0	0	0

a. If you were unable to provide any of the information above, explain why this information could not be provided.	This auditor reviewed the submitted PAQ, resident records, and interview staff and residents onsite to ascertain if there were any sexual harassment allegations made and/or investigations occurred during the 12 months preceding the audit by incident type. The facility reported zero sexual harassment allegations and investigations and my triangulation during the above review corroborated this assessment.

Sexual Abuse and Sexual Harassment Investigation Outcomes

Sexual Abuse Investigation Outcomes

Note: these counts should reflect where the investigation is currently (i.e., if a criminal investigation was referred for prosecution and resulted in a conviction, that investigation outcome should only appear in the count for "convicted.") Do not double count. Additionally, for question brevity, we use the term "inmate" in the following questions. Auditors should provide information on inmate, resident, and detainee sexual abuse investigation files, as applicable to the facility type being audited.

69. Criminal SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

Instructions: If you are unable to provide information for one or more of the fields below, enter an "X" in the field(s) where information cannot be provided.

	Ongoing	Referred for Prosecution	Indicted/Court Case Filed	Convicted/Adjudicated	Acquitted
Inmate-on-inmate sexual abuse	0	0	0	0	0
Staff-on-inmate sexual abuse	0	0	0	0	0
Total	0	0	0	0	0

a. If you were unable to provide any of the information above, explain why this information could not be provided.	This auditor reviewed the submitted PAQ, resident records and interview staff and residents onsite to ascertain if there were any criminal sexual abuse investigation outcomes during the 12 months preceding the audit by incident type. The facility reported zero criminal sexual abuse investigation outcomes and my triangulation during the above review corroborated this assessment.

70. Administrative SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

Instructions: If you are unable to provide information for one or more of the fields below, enter an "X" in the field(s) where information cannot be provided.

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual abuse	0	0	0	0
Staff-on-inmate sexual abuse	0	0	0	0
Total	0	0	0	0

a. If you were unable to provide any of the information above, explain why this information could not be provided.	This auditor reviewed the submitted PAQ, resident records and interview staff and residents onsite to ascertain if there were any administrative sexual abuse investigation outcomes during the 12 months preceding the audit by incident type. The facility reported zero administrative sexual abuse investigation outcomes and my triangulation during the above review corroborated this assessment.

Sexual Harassment Investigation Outcomes

Note: these counts should reflect where the investigation is currently. Do not double count. Additionally, for question brevity, we use the term "inmate" in the following questions. Auditors should provide information on inmate, resident, and detainee sexual harassment investigation files, as applicable to the facility type being audited.

71. Criminal SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

Instructions: If you are unable to provide information for one or more of the fields below, enter an "X" in the field(s) where information cannot be provided.

	Ongoing	Referred for Prosecution	Indicted/Court Case Filed	Convicted/Adjudicated	Acquitted
Inmate-on-inmate sexual harassment	0	0	0	0	0
Staff-on-inmate sexual harassment	0	0	0	0	0
Total	0	0	0	0	0

a. If you were unable to provide any of the information above, explain why this information could not be provided.	This auditor reviewed the submitted PAQ, resident records and interview staff and residents onsite to ascertain if there were any criminal sexual harassment investigation outcomes during the 12 months preceding the audit by incident type. The facility reported zero criminal sexual harassment investigations outcomes and my triangulation during the above review confirmed this assessment.

72. Administrative SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

Instructions: If you are unable to provide information for one or more of the fields below, enter an "X" in the field(s) where information cannot be provided.

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual harassment	0	0	0	0
Staff-on-inmate sexual harassment	0	0	0	0
Total	0	0	0	0

a. If you were unable to provide any of the information above, explain why this information could not be provided.	This auditor reviewed the submitted PAQ, resident records and interview staff and residents onsite to ascertain if there were any administrative sexual harassment investigation outcomes during the 12 months preceding the

	audit by incident type. The facility reported zero administrative sexual harassment investigations outcomes and my triangulation during the above review confirmed this assessment.
Sexual Abuse and Sexual Harassment Investigation Files Selected for Review	
Sexual Abuse Investigation Files Selected for Review	
73. Enter the total number of SEXUAL ABUSE investigation files reviewed/sampled:	0
a. If 0, explain why you were unable to review any sexual abuse investigation files:	Click or tap here to enter text.
74. Did your selection of SEXUAL ABUSE investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	☐ Yes ☒ No ☐ N/A (N/A if you were unable to review any sexual abuse investigation files)
Inmate-on-inmate sexual abuse investigation files	
75. Enter the total number of INMATE-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	0
76. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	☐ Yes ☒ No ☐ N/A (N/A if you were unable to review any inmate-on-inmate sexual abuse investigation files)
77. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	☐ Yes ☒ No ☐ N/A (N/A if you were unable to review any inmate-on-inmate sexual abuse investigation files)
Staff-on-inmate sexual abuse investigation files	
78. Enter the total number of STAFF-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	0
79. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	☐ Yes ☒ No ☐ N/A (N/A if you were unable to review any staff-on-inmate sexual abuse investigation files)
80. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	☐ Yes ☒ No ☐ N/A (N/A if you were unable to review any staff-on-inmate sexual abuse investigation files)
Sexual Harassment Investigation Files Selected for Review	
81. Enter the total number of SEXUAL HARASSMENT investigation files reviewed/sampled:	0
a. If 0, explain why you were unable to review any sexual harassment investigation files:	The facility reported zero sexual harassment investigations in the last 12 months. There were no sexual harassment investigative files to review during the triangulation of the information reviewed in the PAQ, during the staff and

	resident interviews which corroborated this assertion.
82. Did your selection of SEXUAL HARASSMENT investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	☐ Yes ☒ No ☐ N/A (N/A if you were unable to review any sexual harassment investigation files)

Inmate-on-inmate sexual harassment investigation files	
83. Enter the total number of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	0
84. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files include criminal investigations?	☐ Yes ☒ No ☐ N/A (N/A if you were unable to review any inmate-on-inmate sexual harassment investigation files)
85. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	☐ Yes ☒ No ☐ N/A (N/A if you were unable to review any inmate-on-inmate sexual harassment investigation files)
Staff-on-inmate sexual harassment investigation files	
86. Enter the total number of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	0
87. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include criminal investigations?	☐ Yes ☒ No ☐ N/A (N/A if you were unable to review any staff-on-inmate sexual harassment investigation files)
88. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	☐ Yes ☒ No ☐ N/A (N/A if you were unable to review any staff-on-inmate sexual harassment investigation files)
89. Provide any additional comments regarding selecting and reviewing sexual abuse and sexual harassment investigation files. *Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.*	The facility reported zero staff-on-resident sexual abuse and sexual harassment investigations in the last 12 months. There were no staff on resident sexual abuse and sexual harassment investigative files to review during the triangulation of the information provided in the PAQ, from the staff and resident interviews which corroborated this assertion.

Support Staff Information

DOJ-certified PREA Auditors Support Staff

90. Did you receive assistance from any DOJ-CERTIFIED PREA AUDITORS at any point during this audit? *Remember: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.*	☐ Yes ☒ No

a. If yes, enter the TOTAL NUMBER OF DOJ-CERTIFIED PREA AUDITORS who provided assistance at any point during the audit:	Click or tap here to enter text.
Non-certified Support Staff	
91. Did you receive assistance from any NON-CERTIFIED SUPPORT STAFF at any point during this audit? *Remember: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.*	☐ Yes ☒ No
a. If yes, enter the TOTAL NUMBER OF NON-CERTIFIED SUPPORT STAFF who provided assistance at any point during the audit:	0
Auditing Arrangements and Compensation	
92. Who paid you to conduct this audit?	☒ The audited facility or its parent agency ☐ My state/territory or county government (if you audit as part of a consortium or circular auditing arrangement, select this option) ☐ A third-party auditing entity (e.g., accreditation body, consulting firm) ☐ Other

Summary of Audit Findings

Standards Exceeded

Number of Standards Exceeded: 0

List of Standards Exceeded:

Standards Met

Number of Standards Met: 43

Standards Not Met

Number of Standards Not Met: **`0**

List of Standards Not Met: **0**

PREVENTION PLANNING

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

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 agency-wide PREA Coordinator? ☒ Yes ☐ No

- Is the PREA Coordinator position in the upper-level of the agency hierarchy? ☒ Yes ☐ No

- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities? ☒ Yes ☐ No

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*)

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

1. Documents reviewed included:

   a. PREA Audit Questionnaire (PAQ)
   b. LL Brandon III Zero Tolerance Policy (LLBTHFB)
   c. Acknowledgement of receipt and understanding of PREA policy signed by staff, contractors, and volunteers.
   d. Zero Tolerance posters
   e. Organizational Chart

2. Interviews included:

a. Administrative Assistant/PREA Coordinator

3. Site Review / Observation:
   a. Zero Tolerance Sexual Abuse and Sexual Harassment Postings
   b. Agency's Webpage: www.info@northwestlouisianacdc.org

115.311 (a) LLBTHFB does not have a fully completed zero-tolerance policy towards all forms of sexual abuse and sexual harassment to address LLBTHFB's obligations under federal Prison Rape Elimination Act (PREA) standards for preventing, detecting, and responding to sexual abuse and sexual harassment. The LLBTHFB Zero Tolerance Policy is not available to staff, but is available to the resident and is not made available to members of the public due to not being posted on the agency's web page at www.info@northwestlouisianacdc.org . Under the general provisions section of LLBTHFB's PREA policy it outlines the agency's approach towards preventing, detecting, and responding to sexual abuse and sexual harassment. *The facility is not in compliance with this provision.*

115.311 (b) The agency Zero Tolerance policy states "LLBTHFB a designates upper-level staff member as the agency wide Administrative Assistant/PREA Coordinator" (pg. 2). The agency has a designated Administrative Assistant as the PREA Coordinator. She holds an upper-level position and has stated during her interview that she has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in her facilities. *The facility is in compliance with this provision.*

115.311 (c) The agency's Zero Tolerance policy states "LLBTHFB a designated the Administrative Assistant/PREA Coordinator at each LLBTHFB operated residential facilities. This staff member's duties must be structured to allow sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards". During the interview with the Administrative Assistant/PREA Coordinator she stated that she has sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards. *The facility is in compliance with this provision.*

This facility is not in compliance with this standard.

Corrective Action Findings: LLBTHFB must fully develop, implement and train their staff on the Zero Tolerance policy, post it on the agency's website so that the public can have access to it and ensure that the staff understand the agency's efforts towards preventing, detecting, responding and reporting of sexual abuse and sexual harassment. This is to be verified by receipt of the approved Zero Tolerance policy and acknowledgement statements from all of the staff indicating that they have been trained on this policy in order to be in compliance with this standard.

Corrective Action Response: The PREA Coordinator did provide to this auditor with a revised copy of their Zero Tolerance policy for review, indicated that it was posted on the facility's display board pending uploading to their website. The PREA Coordinator did provide a picture of the display case in the lobby of the facility where the policy was posted for public review. She did provide copies of the signed training acknowledgement forms from the staff indicating that they have been trained on this revised policy. This facility is in compliance with this standard.

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*)

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

1. Documents reviewed included:
   a. PREA Audit Questionnaire (PAQ)
   b. LL Brandon III Zero Tolerance Policy (LLBTHFB)
   c. Contract with Louisiana Office of Juvenile Justice (LOJJ)
2. Interviews included:
   a. Executive Director
   b. Administrative Assistant/PREA Coordinator
   c. Agency Contract Administrator
3. Site Review / Observation:
   a. Office where contracts are stored

115.312 (a) LLBTHFB is not a public agency but is a non-profit, private agency run facility. LLBTHFB stated on the PAQ that the agency has not entered into a contract for the confinement of their residents. However, LLBTHFB does contract with Louisiana Office of Juvenile Justice to provide residential services for their residents. The Facility Director and the Administrative Assistant/PREA

Coordinator confirmed in their interviews that the agency does not contract for the confinement of their residents with other entities but do contract with Louisiana Office of Juvenile Justice to provide residential services for their residents. LLBTHFB did provide this auditor with a copy of the contract with the Louisiana Office of Juvenile Justice. *This facility is in compliance with this provision.*
115.312 (b) LLBTHFB contracts with the Louisiana Office of Juvenile Justice (LOJJ) to provide residential services for their residents. A review of the contract LOJJ, they do state that LLBTHFB will "comply with the Final Rule of the Prison Rape Elimination Act (PREA) of June 20, 2012 and with all applicable PREA standards". This was confirmed during the interview of the Agency Contract Administrator, which is the Executive Director. LOJJ also have a clause in their contract for monitoring LLBTHFB to ensure that they are in compliance with the PREA standards during the contract period. *This facility is in compliance with this provision.*

Corrective Action Findings: None.

This facility is in compliance with this standard.

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*)

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

1. Documents reviewed included:
   a. PREA Audit Questionnaire (PAQ)

b. LLBTHFB Zero Tolerance Policy
c. LLBTHFB Staffing Assessment and Staffing Plan
d. LLBTHFB Unannounced Rounds Logs
e. LLBTHFB Facility Schematics of Brandon Transitional Home for Boys
f. Memorandum for Supervision and Monitoring

2. Interviews included

a. Random residents
b. Random staff
c. Executive Director
d. Administrative Assistant/PREA Coordinator

3. Site Review / Observation:

b. Staff to resident ratio observations throughout onsite phase.

115.313 (a) LLBTHFB's Zero Tolerance Policy states that "LLBTHFB develops and implements a written staffing plan to provide adequate levels of staffing or video monitoring (if applicable) to protect resident against sexual abuse. (pg.3, (3), (A), (I))". The PAQ reflected no instances of a deviation from the planned staff to resident ratio, which is 1 to 5 during waking hours and 1 to 16 during sleeping hours. LLBTHFB is a non-secure residential facility, whose primary resident population are from the Louisiana Office of Juvenile Justice. The Executive Director has elected to have LLBTHFB PREA audited once because of his desire to receive and provide services to more juvenile justice youth around the state of Louisiana.

LLBTHFB did not provide a staffing plan to this auditor during the pre-audit phase for his review. Based on the average resident population by month for the past 12 months, which is 16 and taking into consideration a low staff turnover rate in the past 12 months, this auditor found no obvious reason to believe there had been any deviation from the facility's staffing plan. LOJJ contractual agreement requires that LLBTHFB maintains a 1 to 5 and a 1 to 12 staff/resident ratio. This is well below the PREA requirement of staff to resident ratio. LLBTHFB does use surveillance cameras to aid the facility staff in monitoring the residents. There are 24 cameras interior/exterior of the facility: At the front entrances, in the dining rooms, in the common areas, the group rooms and at the rear of the building. Through the staff interviews, this auditor found no reports of short staffing or ratio deviations in the daily monitoring and supervision of the residents. There were no findings of judicial inadequacy, inadequacies from a Federal investigative agency, or inadequacies from an internal or external oversight body (e.g., LOJJ). During the site review this auditor did not identify any blind spots or areas in the facility where staff or residents may be isolated.

The staffing plan also did not take into consideration the following:

- The number and placement of supervisory staff
- Employees work shifts,
- Applicable state, local laws, regulations and standards
- Prevalence of substantiated and unsubstantiated incidents of sexual abuse
- Other relevant factors

Further evidence ascertained during the interviews of the Executive Director and the Administrative Assistant/PREA Coordinator. Both these individuals confirmed that LLBTHFB's will develop a staffing

plan to ensure that adequate staffing is maintained in the facilities to protect the residents, and that the video monitoring is employed, as part of the staffing plan, further detect, prevent and protect residents against sexual abuse. *The facility is not in compliance with this provision.*

115.313 (b) The LLBTHFB Zero Tolerance Policy as well as their contract with LOJJ requires constant supervision and monitoring of the residents while in the facilities. The policy states that the facility maintains a 1 to 6 ratio during waking hours and 1 to 12 staff ratio during sleeping hours except during limited or discrete exigent circumstances. Onsite observations by this auditor, during the audit, exceeded the established written ratios. Observed ratios were 4:20 during sleeping hours, 1:6, 1:2, and 2:12 during waking hours which exceeds the standards. The Administrative Assistant/PREA Coordinator stated during her interview that there have been no deviations from the ratio in the last 12 months. *The facility is in compliance with this provision.*

115.313 (c) LLBTHFB facility roster showed 38 full time staff employed of which 1 is the Executive Director, 29 are direct care staff, 3 shift supervisors, 1 case manager, 1 cook, 2 administrative office staff, 1 PREA Coordinator. The resident roster provided during the pre-audit phase reflected their current population of 20 residents. This auditor found no evidence nor was there a report of the staff to resident ratio deviating from the planned ratio of 1:8 daytime. This auditor found no evidence nor was there a report of the staff to resident ratio deviating from the planned ratio of 1:16 at nighttime. LLBTHFB did not document any deviations from the staffing ratio of any limited or discrete exigent circumstances. LLBTHFB is a non-secure facility and calculating the ratios are not applicable LLBTHFB is obligated by LOJJ regulations and contractual agreement to maintain a 1 to 6 daytime and 1 to 12 nighttime staff to resident ratio. *The facility is in compliance with this provision.*

115.313 (d) LLBTHFB's Executive Director and Administrative Assistant/PREA Coordinator indicated during their interviews that they did not confer in the last 12 months in the development of the staffing plan assessment but did discuss what adjustments were needed in the development of the staffing plan, which was provided to this auditor during the pre-audit phase. They indicated that they will also consider the following in the development of the staffing plan:

- Prevailing staffing patterns
- Deployment of video monitoring systems and other technologies
- Available resources needed to adhere to the staffing plan

The facility is not in compliance with this provision.

115.313. (e) LLBTHFB's Executive Director did indicate during his interview that the direct care staff shift supervisors and the Administrative Assistant/PREA Coordinator do conduct unannounced rounds to identify and deter staff sexual abuse and sexual harassment. During the interview with the Administrative Assistant/PREA Coordinator and the Intermediate Level Staff, they both indicated that they do conduct unannounced round in both facilities at least twice a month on all three shifts. The Unannounced Logs were not provided during the pre-audit phase to assess the dates, times and supervisory staff who conducted the unannounced rounds for the last 12 months, thereby corroborating their interview statement. This auditor also found evidence on the PAQ reflecting that higher-level staff do conduct unannounced rounds on all shifts. *The facility is not in compliance with this provision.*

LLBTHFB's Zero Tolerance Policy does states that disciplinary action will occur if staff alert other staff of the unannounced rounds. During the random staff interviews the staff did explain the unannounced rounds do occur and that they are aware of the consequences if they alert other staff of the unannounced rounds. During the interview with the direct care staff shift supervisors, they indicated that

staff are aware of the consequences of alerting other staff of an unannounced round and because of the configuration of the houses, that they can enter through the back door and or front door quietly to monitor the staff during the late-night hours to ascertain if they are alert and performing their responsibilities. LLBTHFB does have a policy that prohibits staff from alerting other staff of an unannounced round being made by an intermediate and or higher-level staff member. *The facility is in compliance with this provision.*

The facility is not in compliance with this standard.

Corrective Action Findings: The facility needs to ascertain what is LOJJ's staff to resident ratio during waking and sleeping hours and develop a staffing plan for 2021 and institutionalize this practice every year. The facility also needs to provide this auditor with copies of the unannounced rounds log for the next 3 months to demonstrate institutionalization of this practice in order to be in compliance with this standard.

Corrective Action Response: The PREA Coordinator did provide a copy of the contract with LOJJ that corroborated with their Zero Tolerance policy, which does indicate the staff-to-youth ratio of 1-6 during waking hours and 1-12 during sleeping hours. She also provided this auditor with a copy of their staffing plan as well as copies of the unannounced round log for the last 90 days demonstrating that this practice has been institutionalized. *The facility is in compliance with this standard.*

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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. LLBTHFB Zero Tolerance Policy
c. Staff Training Records
d. National PREA Resource Center's Cross Gender Pat Search curriculum (need copy of this)
e. Search logs (need copies of these for last 12 months)

Interviews included:

a. Random residents
b. Random staff
c. Non-security staff involved in cross gender searches
d. First Responder, security and non-security staff

Site Review / Observation:

a. Residential Housings (units)
b. Monitoring Stations

115.315 (a): LLBTHFB Zero Tolerance policy states "that they will maintain restrictions and limitations on cross-gender searches and shall always refrain from conducting cross gender strip or cross gender visual body cavity searches, except in exigent circumstances or by a medical practitioner". This is an all-male facility and all staff, including female, have not been trained on how to conduct a cross gender pat search.

During a review of the random staff training files and the interviews, it revealed that they were not trained on how to conduct a cross gender pat down search. 4 of the random female direct care staff interviewed corroborated this finding and further stated that female staff do not conduct pat down searches on the male residents at any time. They further indicated that there has not been an exigent circumstance in the last 12 months to warrant such a cross gender pat down search. *The facility is not in compliance with this provision.*

115.315 (b): LLBTHFB is an all-male facility and interviews conducted with the 12 random staff, inclusive of the female direct care staff, revealed that the female staff have not conducted cross gender pat down searches in non-exigent circumstances in the last 12 months. The Administrative Assistant/PREA Coordinator corroborated this assertion. *The facility is in compliance with this provision.*

115.315 (c): LLBTHFB Zero Tolerance policy states "that they will maintain restrictions and limitations on cross-gender searches and shall always refrain from conducting cross gender strip or cross gender visual body cavity searches, except in exigent circumstances or by a medical practitioner". LLBTHFB Administrative Assistant/PREA Coordinator stated during her interview that they do not conduct cross gender strip searches and cross gender visual body cavity searches in her facilities. Therefore, there is no need to document these protocols. *The facility is in compliance with this provision.*

115.315 (d): LLBTHFB Zero Tolerance policy states that "staffing patterns and physical barriers are implemented to 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's single bedrooms are designed to prohibit cross gender viewing of resident performing such personal actions because of having doors to avoid staff or other residents from viewing

them in both locations. The facility schematic shows 36 single bedrooms with single bathroom/shower area with a door and 2 multiple bedrooms, each having 2 beds in them, whereas they share a bathroom/shower area. This auditor confirmed the schematic plans of these areas during the site review.

LLBTHFB requires staff of the opposite gender to announce their presence when entering the dormitory areas to the bedroom and bathroom areas. During the interviews with the all 12 of the random staff they all confirmed that the female staff do make an announcement saying: The random male staff further stated that the female does not enter the resident's bedrooms during showering, changing of clothing and restroom routines. This statement was also confirmed during the random resident interviews.12 out of 12 random residents interviewed stated that the female staff do not enter their rooms during shower, changing of clothing and restroom routines but when they do come to their room door, they knock and announce their presence before entering the resident's room.

This auditor did observe a female staff knock and announce her presence when seeking to enter into the bedroom of a residents during the onsite visit. *The facility is in compliance with this provision.*

115.315 (e) LLBTHFB Zero Tolerance Policy states that "staff do not search or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status. The status may be determined during conversations with the resident, by reviewing medical records, or as part of a broader medical examination conducted in private by a medical practitioner". The Administrative Assistant/PREA Coordinator stated during her interview that this policy is adhered to by her staff and that there have been no transgender or intersex residents in her population in the last 12 months. *The facility is in compliance with this provision.*

115.315 (f) LLBTHFB did not provide evidence that all of the direct care staff have been train 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 including how to conduct searches of transgender and intersex residents in a professional and respectful manner. A review of the employees training records revealed that all staff have not received cross gender pat search training, searches of transgender and intersex residents. There was no acknowledgement statement and signature on the training roster. This is an all-male facility. *The facility is not in compliance with this provision.*

This facility is not in compliance with this standard.

Corrective Action Findings: The facility needs to train all staff on how to conduct a cross gender pat search of transgender and intersex residents in a professional and respectful manner, provide a copy of the training module utilized, and copies of the staff's acknowledgement statement for this training to this auditor for his review, in order to be in compliance with this standard,

Corrective Action Response: The PREA Coordinator did provide to this auditor signed training acknowledgement forms indicating that they had been trained on how to conduct a cross gender pat search. She also provided the cross-gender training module utilized from the PRC website, which she utilized to train staff. This facility is in compliance with this standard.

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*)

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

a. PREA Audit Questionnaire (PAQ)
b. LLBTHFB Zero Tolerance Policy
c. Intake Screening Forms
d. Resident Orientation Handbook (English and Spanish)
e. PREA Zero Tolerance Posters
f. Caddo Parish School Board Memorandum
g. Caddo Parish School English Language Learner Department Memorandum

Interviews included:

a. Random residents
b. Random staff
c. Administrative Assistant/PREA Coordinator
d. First Responder, security and non-security staff

Site Review / Observation:

a. Residential housing postings
b. Administrative area postings

115.316 (a) The LLBTHFB Zero Tolerance Policy states that "LLBTHFB will take reasonable steps to ensure meaningful access to all aspects of the agency's efforts prevent, detect, and respond to sexual abuse and sexual harassment residents who are:

- Deaf or hard of hearing
- Blind or have low vision
- Limited English Proficient
- Intellectually disabled
- Psychiatric disabled
- Speech disability

Appropriate steps will be taken to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's effort to prevent, detect, and respond to sexual abuse and sexual harassment.

LLBTHFB has not taken steps to ensure that there is effective communication with residents who are:

- Deaf or hard of hearing
- Blind or have low vision
- Limited English Proficient
- Intellectually disabled
- Psychiatric disabled
- Speech disability

Nor have they entering into an agreement with the Caddo Parish School Board to provide these services to the residents in their facility. LLBTHFB also has not provided information or documentation regarding access to the language or interpreting line service, when needed, for residents requiring interpreting in another language. The Administrative Assistant/PREA Coordinator indicated during her interview that an interpreting service provider will provide these services to LLBTHFB residents as needed. She did not provide a copy of the memorandum of agreement from the Caddo Parish School Board. *The facility is not in compliance with this provision.*

115.316. (b) LLBTHFB Administrative Assistant/PREA Coordinator did indicate during her interview that they will do whatever is necessary to ensure the residents understand the PREA standards and their rights. They will utilize, when necessary, staff as translators, a language or interpreting line service and that the Caddo Parish School English Language Learner Department will provide resources for residents who may be deaf, speech impaired, limited in English proficiency, blind and or low vision or who are psychiatric or are intellectually impaired. At the time of the audit, nor in the past 12 months, did the facility have any resident who were assessed as needing interpreting services, had a disability or were limited English proficient. This determination was made based on interviews of the Intake staff, program staff, and a review of the resident files. *The facility is in compliance with this provision.*

115.316 (c) LLBTHFB Zero Tolerance policy states that LLBTHFB does not use other residents to interpret, read, or otherwise assist except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise safety, the performance of first responder duties, or

an investigation". The Administrative Assistant/PREA Coordinator and Intake staff stated during their interviews that LLBTHFB does not use resident interpreters or assistants for reporting sexual abuse and sexual harassment allegations in the last 12 months. During the random staff interviews all 12 of the staff indicated that LLBTHFB has not utilized resident interpreters or assistants for reporting sexual abuse and sexual harassment allegations. *The facility is in compliance with this provision.*

This facility is not in compliance with this standard.

Corrective Action Findings: LLBTHFB must attempt to obtain a Memorandum of Understanding from Caddo Parish School Board indicating that they will provide services to residents who are deaf or hard of hearing, blind or have low vision, Limited English Proficient, intellectually disabled, psychiatric disabled and who have a speech disability. LLBTHFB must also provide an agreement with the Language or an Interpreting Line service provider to provide interpreters when needed, in order to be in compliance with this standard.

Corrective Action Response: The PREA Coordinator did provide to this auditor a memorandum indicating that they are pursuing a Memorandum of Understanding with the Caddo Parish School Board to provide services to residents who are deaf or hard of hearing, blind or have low vision, Limited English Proficient, intellectually disabled, psychiatric disabled and who have a speech disability. She also provided a memorandum indicating that the Caddo Parish School English Language Learner Department through the Booker T. Washington School, would provide interpreting services when needed for PREA purposes in the facility. The facility is in compliance with this standard.

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 record 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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. LLBTHFB Zero Tolerance Policy
c. Criminal Records and Child Abuse Registry Check Documentation
d. Employment Application
e. Employee PREA Self-Disclosure Forms
f. Staff Training Records
g. Resident Orientation Handbook (English and Spanish)
h. PREA Sexual Abuse and Sexual Harassment Posters

Interviews included:

a. Executive Director
b. Human Resources
c. Administrative Assistant/PREA Coordinator

Site Review / Observation:

a. None to observe.

115.317 (a). LLBTHFB Zero Tolerance policy states that "LLBTHFB does not hire or promote anyone who may have contact with resident 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;
(ii) who have 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, of if the victim did not consent or was unable to consent or refuse.
(iii) Enlist the services of any contractor who has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution; or who have 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, of if the victim did not consent or was unable to consent or refuse.
(iv) Enlist the services of any contractor who has been 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.

The Human Resource staff confirmed during his interview that LLBTHFB has not hired, promoted, or contracted with anyone who meets the criteria listed above in (I) through (iv). A review of employee files revealed that there was no documented evidence of LLBTHFB hiring, promoting or utilizing the services of any contractors during the last 12 months as stated above. *The facility is in compliance with this provision.*

115.317 (b) LLBTHFB Zero Tolerance Policy states that "For any person who may have contact with juveniles, LLBTHFB considers any incidents of sexual harassment in determining whether to hire, promote, or contract for services". The Human Resource staff indicated during his interview that a thorough criminal background check, pre-employment reference checks, and a child abuse registry check are conducted before an applicant or contractor is offered a position. He further stated that a "hit" would automatically come to him via email from the Louisiana Department of Public Safety (LDPS) if any of his current employees are arrested or come in contact with law enforcement. A review of the employee and contractor files revealed no documented evidence of LLBTHFB hiring, promoting or procuring the services of a contractor in violation of this provision. *The facility is in compliance with this provision.*

115.317 (c) LLBTHFB Zero Tolerance Policy, (pg.6) states that "before hiring new employees who may have contact with resident, LLBTHFB Executive Director will:

(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.

A review of the employee files revealed that LLBTHFB have been conducting background checks and completing reference checks, however they did not have documented proof of attempts to ask previous institutional employer information regarding substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. During the interview with the Human Resource personnel stated that none of the last 23 news hires came from institutional facilities. During the employee file review, it was ascertained that no institutional reference check had been performed on these 23 new hires.

During the onsite audit this auditor was not provided a sample letter to send to a prior institutional employer for information substantiated related incidents and resignations. Further review of the employee files revealed that documented child abuse registry checks through the Department of Health Services (DHS) have been conducted on all employees in the last 12 months. *The facility is not in compliance with this provision.*

115.317 (d) LLBTHFB Zero Tolerance Policy states that "before enlisting the services of a contractor who may have contact with residents, the Executive Director will:

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

Further review of the contractor file revealed that documented child abuse registry checks through the Louisiana Department of Children and Family Protection had been conducted in the last 12 months. *The facility is in compliance with this provision.*

115.317 (e) LLBTHFB does conduct criminal background checks every five years of current employees and on contractors who may have contact with residents. This was evidenced through the employee file review of the staff and contractor and confirmed in interviews with the Executive Director and Human Resource staff. *The facility is in compliance with this provision.*

115.317 (f) LLBTHFB Zero Tolerance Policy does" asks applicants and employees who may have contact with youth directly about previous misconduct described in subparagraph (A) of this paragraph in written applications or interviews for hiring or promotion and in any interviews or written self-evaluations conducted as part of reviews of current employees. LLBTHFB employees have a continuing affirmative duty to disclose any such misconduct. Material omissions regarding such misconduct or the provision of materially false information is grounds for termination of employment". LLBTHFB did not provide during the pre-audit phase a completed "PREA Self-Disclosure" document on each employee as part of their continuing affirmative duty to disclose any such misconduct. *The facility is not in compliance with this provision.*

115.317 (g) LLBTHFB Zero Tolerance Policy does indicates" Material omissions regarding such misconduct or the provision of materially false information is grounds for termination of employment". The Human Resource staff did indicate during her interview that all staff and contractors have been

informed of this policy and that there have been no violations of this policy in the last 12 months. *The facility is in compliance with this provision.*

115.317 (h) LLBTHFB Zero Tolerance Policy does state, "that unless prohibited by law, LLBTHFB 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". During the interview with the Human Resource personnel, he indicated 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 onsite audit the LLBTHFB Human Resource staff indicated that he had not received any requests for information from a juvenile institution on a current staff. The Administrative Assistant/PREA Coordinator did not provide to this auditor a copy of the sample letter to be sent to an institutional employer of a potential hire The Human Resource personnel also indicated that he has not requested information on any of the 23 new hires in 2020. *The facility is not in compliance with this provision.*

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Corrective Action Findings: LLBTHFB must have all their employees to sign an affirmative duty to report form (PREA Self-Disclosure Form) and they must also develop a sample letter to send to a prior institutional employer for information on substantiated related incidents and resignations of a potential hire for future references and usage. They must also send a copy of said letter to this auditor for his review, in order to be in compliance with this standard.

Corrective Action Response: The PREA Coordinator did provide to this auditor signed PREA Employment Disclosure forms on each employee regarding their affirmative duty to report as well as a sample copy of the letter to be sent to an institutional employer of a potential employee to ascertain if they have any substantiate sexual abuse related incidents. The facility is in compliance with this standard.

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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. Facility Schematics

Interviews included:

a. Executive Director
b. Administrative Assistant/PREA Coordinator

Site Review / Observation:

a. Observations during the site review of the camera locations throughout the facility

115.318 (a) LLBTHFB Zero Tolerance Policy states that "When designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, LLBTHFB will consider the effect of the design, acquisition, expansion, or modification on the agency's ability to protect residents from sexual abuse". The Administrative Assistant/PREA Coordinator indicated in her interview that there have not been any major expansion or modification of the existing. The C & D wings of the facility are being renovated to bring them up to City code. She further indicated that if any major modifications occur that they will consider the effect of the design, acquisition, expansion, or modification regarding LLBTHFB's ability to protect residents from sexual abuse. *The facility is in compliance with this provision.*

115.318 (b) LLBTHFB Zero Tolerance Policy states that "When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, LLBTHFB considers how such technology may enhance the agency's ability to protect youth from sexual abuse".
During the site review this auditor notices that LLBTHFB has installed 24 cameras in the interior and exterior of the facility to enhance the agency's ability to protect residents from sexual abuse. No other cameras or electronic surveillance systems have been installed since the last audit nor in the last 12 months. *The facility is in compliance with this provision.*

This facility is in compliance with this standard.

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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. LL Brandon III RTC Zero Tolerance Policy

c. Memorandum on Evidence Protocol and Forensic Examinations
d. Memorandum of Understanding Project Celebration

Interviews included:

a. Administrative Assistant/PREA Coordinator
b. Human Resources
c. Agency Contract Administrator
d. SAFE/SANE Nurse at the Willis Knight Hospital
e. Project Celebration
f. Random staff interviews
g. Random resident interviews

Site Review / Observation:

a. Facility postings
b. Brochures available to residents

115.321 (a) LLBTHFB is not responsible for investigating allegations of sexual abuse and sexual harassment. The Shreveport Police Department conducts the criminal investigations and the Office of Juvenile Justice conducts the administrative investigations and they will follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative and criminal prosecutions. *The facility is in compliance with this provision.*

115.321 (b) LLBTHFB is not responsible for investigating allegations of sexual abuse and sexual harassment. The Administrative Assistant/ PREA Coordinator did indicate during her interview that the protocol being utilized by the Shreveport Police Department, who conducts the criminal investigations and the Louisiana Office of Juvenile Justice, who conducts the administrative investigations is developmentally appropriate for youth and shall be 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, Adult/Adolescents. *The facility is in compliance with this provision.*

115.321 (c) LLBTHFB Zero Tolerance Policy states that "when evidentiarily or medically appropriate, LLBTHFB will transport residents who experience sexual abuse to the hospital, clinic or emergency room that can provide for medical examination by a Sexual Assault Nurse Examiner (SANE) and that such medical examinations are provided at no financial cost to the resident.

The Administrative Assistant/PREA Coordinator stated during her interview that in the event of a sexual abuse allegation, LLBTHFB will call the Shreveport Police Department for criminal investigation and they would take the resident to Willis Knight and/or LSU Oschner Hospitals for the SANE examination. The Willis Knight and/or LSU Oschner Hospital services also include services provided through Project Celebration. During the interview with the SANE Nurse, she that the Willis Knight and/or LSU Oschner Hospitals provides compassionate, sensitive, timely care for victims of violent crimes, child abuse and neglect. The SANE Nurse further explained that she was the lead SANE 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 states that "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.

The Administrative Assistant/PREA Coordinator further indicated during her interview that there have been no referrals of sexual abuse victims to the Willis Knight and/or LSU Oschner Hospital in the last 12 months. A review of the resident files corroborated this assertion. *The facility is in compliance with this provision.*

115.321 (d) LLBTHFB Zero Tolerance Policy states that LLBTHFB seeks to secure victim advocacy services from a local rape crisis center". Rape Crises Center services are provided free of charge by the Project Celebration a community-based organization that provide emotional support, counseling and advocacy services. The Administrative Assistant/PREA Coordinator did not provide a Memorandum of Understanding between LLBTHFB and the Project Celebration to corroborate the services to be offered for a sexual abuse victim.

According to the Project Celebration Support Staff representative, once a sexual abuse victim (resident) is referred to the Willis Knight and/or LSU Oschner Hospital will receive "wraparound" services e.g., SANE examination, victim advocacy, emotional support and counseling service through this established consortium network. The Administrative Assistant/PREA Coordinator indicated during her interview that a victim advocate will always made available to victims of sexual abuse by Project Celebration, though they have not received a memorandum of understanding from Project Celebration after serval phone call attempts. She further indicated that there have been no referrals of sexual abuse victims to the Willis Knight and/or LSU Oschner Hospitals in the last 12 months. A review of the resident files corroborated this assertion. *The facility is not in compliance with this provision.*

115.321 (e) LLBTHFB Administrative Assistant/PREA Coordinator indicated during her interview that at a sexual abuse victim requests a staff member from Project Celebration would accompany the resident through the forensic medical examination process and investigatory interviews. However, the emotional support and crisis intervention services through the Project Celebration remains available 24/7 to support victims through the forensic medical examination process and investigatory interview process also. These services include the forensic examination, emotional support, crises intervention, information, and referrals. During the phone interview with the SANE Nurse at the Willis Knight Hospital, she confirmed that she is qualified to conduct Sexual Assault Medical Forensic Examinations (SANE) for obtaining usable evidence for administrative or criminal investigations. *The facility is in compliance with this provision.*

115.321 (f) LLBTHFB Administrative Assistant/PREA Coordinator did not provide to this auditor with proof documentation in the form of a memorandum confirming that the Shreveport Police Department will conduct all criminal investigations and that the Louisiana Office of Juvenile Justice (LOJJ) would conduct the administrative investigations. Neither did she provide a memorandum from either investigative entity requesting that they follow the requirements of paragraphs (a) through (e) of this section. *The facility is not in compliance with this provision.*

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

115.321. (h) The Administrative Assistant/PREA Coordinator stated during her interviews that LLBTHFB would always make a victim advocate from Project Celebration available to victims. *The facility is in compliance with this provision.*

This facility is not in compliance with this standard.

Corrective Action Findings: The facility needs to provide a Memorandum of Understanding from Project Celebration for the provision of emotional support and crisis counseling for alleged victims of

sexual abuse in LLBTHFB. They must also provide a memorandum from both investigative entities requesting that they follow the requirements of (a) through (e) of this section in order to be in compliance with this standard.

Corrective Action Response: The PREA Coordinator did provide to this auditor a memorandum indicating their attempts to confirm that Project Celebration would be providing emotional support and crisis counseling for alleged victims of sexual abuse at LLBTHFB. She also provided a memorandum indicating what entities would conduct the criminal and administrative sexual abuse and sexual harassment investigations as applicable. The facility is in compliance with this standard.

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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. LL Brandon III RTC Zero Tolerance Policy
c. Executive Director's Memorandum regarding Shreveport Police Department and the Louisiana Office of Juvenile Justice
d. Executive Director's Memorandum of Understanding regarding the Project Celebration
e. Staff Training Files

Interviews included:

a. Administrative Assistant/PREA Coordinator
b. Executive Director
c. SAFE/SANE Nurse at Willis Knight Hospital
d. Project Celebration - 24-hour hotline and services
e. Random staff interviews
f. Random resident interviews

Site Review / Observation:

a. Facility postings
b. Brochures available to residents
c. Facility's website: www.info@northwestlouisianacdc.org

115.322 (a) The LLBTHFB Zero Tolerance Policy states that "that all allegations of sexual abuse and sexual harassment are reported to and investigated by the Louisiana Office of Juvenile Justice for administrative investigations and the Shreveport Police Department for criminal investigations". During the past 12 months the Administrative Assistant and Executive Director reported during their interview that there were no investigation of sexual abuse or sexual harassment. Upon conducting a file review of staff and resident files, this auditor did not see any investigative documentation in these files. *The facility is in compliance with this provision.*

115.322 (b) LLBTHFB Zero Tolerance Policy states that "all allegations of sexual abuse and sexual harassment are assigned to the appropriate agency, Louisiana Office of Juvenile Justice for administrative investigations and to the Shreveport Police Department for criminal investigation". Since this is their first audit, LLBTHFB Zero Tolerance Policy was not finalized nor was it posted on the

agency web page. The Zero Tolerance Policy is not in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an appropriate agency with the legal authority to conduct criminal investigations. Currently, there is not Zero Tolerance policy *The facility is not in compliance with this provision.*

115.322 (c) LLBTHFB Zero Tolerance Policy states that "all allegations of sexual abuse and sexual harassment are assigned to the appropriate agency, the Louisiana Office of Juvenile Justice for administrative investigations and to the Shreveport Police Department for criminal investigation". The PREA Coordinator and the Executive Director did state during their interviews that administrative sexual abuse and sexual harassment allegations would be investigated by the Louisiana Office of Juvenile Justice and that criminal sexual abuse and sexual harassment allegations would be investigated by the Shreveport Police Department. *The facility is in compliance with this provision.*

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

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

This facility is not in compliance with this standard.

Corrective Action Findings: The facility needs to develop, implement and institutionalize the practice of their Zero Tolerance policy, post it on their website or in another place where the public can view it, and ensure that the Shreveport Police Department and the Louisiana Office of Juvenile Justice are aware of its responsibilities, in the form of proof documentation i.e., memorandum regarding sexual abuse and sexual harassment investigations in order to be in compliance with this standard.

Corrective Action Response: The PREA Coordinator did provide to this auditor a copy of their revised Zero Tolerance policy, signed staff acknowledgement forms to indicate that all staff are aware of this policy and did provide a memorandum from the Executive Director indicating that the Louisiana Office of Juvenile Justice and the Shreveport Police Department acknowledge and are aware of their investigative responsibilities. The facility is in compliance with this standard.

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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. LL Brandon III RTC Zero Tolerance Policy
c. Employee Training File Documentation
d. PREA training curriculum for employees

Interviews included:

a. Executive Director
b. Administrative Assistant/PREA Coordinator
c. Random Staff
d. Intermediate and Higher-Level staff

Site Review / Observations:

a. Employee files and training records

115.331 (a) The LLBTHFB Zero Tolerance Policy states that it will provide PREA related training to all its employees who may have contact with resident". LLBTHFB training addresses:

- How to fulfill their PREA responsibilities under LLBTHFB 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.

It was ascertained during the interviews conducted with the 12 random staff that the PREA training they received cover the above 11 points as required. LLBTHFB utilizes the National Institute of Corrections (NIC) training titled "PREA: Your role in Responding to Sexual abuse" when training their staff as well as the 8-hour PREA Employee Training from the PREA Resource Center. *The facility is in compliance with this provision.*

115.331 (b) The Administrative Assistant/PREA Coordinator stated that the PREA training is tailored to the unique needs and attributes a gender of the residents at the facility. This is also corroborated from the PAQ response. LLBTHFB is a single gender (all-male) facility and the staff of the opposite gender receive the same training regardless of what residential housing unit they are assigned to. The training documentation reviewed and received by this auditor demonstrates that LLBTHFB is not in compliance with this provision. The staff received PREA training as provided during the new employee orientation training but have not received it annually or every 2 years as a refresher training as of the onsite visit. *The facility is not in compliance with this provision.*

115.331 (c) LLBTHFB Administrative Assistant/PREA Coordinator did provide to this auditor during the pre-audit phase written verification all of the staff received the initial PREA training in August of 2020 and they all signed an acknowledgement statement that they understood their PREA responsibilities. The Administrative Assistant/PREA Coordinator indicated during her interview that the staff have not received any refresher PREA training every 2 years. No staff have received any training on the facility's Zero Tolerance policy because there is none. This also was confirmed when reviewing the employee training files. *The facility is not in compliance with this provision.*

115.331 (d) The LLBTHFB Administrative Assistant/PREA Coordinator did provided to this auditor training documentation where the staff being trained acknowledged with their signature that they understand the training they received. During the interviews with all of the staff it was ascertained that they had a good understanding of 115.331 (a, 1-11) and 115.331 (b), and 115.331 (c) thereby corroborating their signed acknowledgement statement. *The facility is in compliance with this provision.*

This facility is not in compliance with this standard.

Corrective Action Findings: The facility needs to provide comprehensive PREA training to all its current staff and refresher training to all staff every 2 years if not conducting annual PREA training and must provide proof documentation that this has occurred. The facility needs to ensure that the staff have received and been trained on the revised Zero Tolerance policy. Documentation in the form of acknowledgement statements attesting that each staff have received this training must also be provided to this auditor for his review in order to be in compliance with this standard.

Corrective Action Response: The PREA Coordinator did provide to this auditor for his review signed acknowledgement statements from each current staff indicating that they have received training in the revised Zero Tolerance policy as well as been received PREA training utilizing the Moss Group training modules on the PRC website. She also provided the training modules utilized as proof documentation of the same. The facility is in compliance with this standard.

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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. LL Brandon III RTC Zero Tolerance Policy

Interviews included:

a. Administrative Assistant/PREA Coordinator
b. Random Staff

Site Review / Observations:

a. None

115.332 (a) The LLBTHFB Zero Tolerance Policy states that "LLBTHFB ensures and documents all volunteers and contractors who have direct access to resident have been trained on and understand their responsibilities under PREA and any other LLBTHFB policies and procedures". The Administrative Assistant/PREA Coordinator indicated during her interview that they have not employed no recruited any volunteers or contractors to provide a service in this facility in the last 12 months. A review of the files reveals that there have been no volunteers or contractors employed in LLBTHFB in the last 12 months. *The facility is in compliance with this provision.*

115.332 (b) The LLBTHFB Administrative Assistant/PREA Coordinator did not provide documentation of a volunteer or contractor's acknowledgement of their PREA responsibilities since they have not procured their services in the last 12 months. A review of the files reveals that there have been no volunteers or contractors employed in LLBTHFB in the last 12 months. *The facility is in compliance with this provision.*

115.332 (c) The Administrative Assistant/PREA Coordinator indicated during her interview that LLBTHFB would maintain documentation confirming that the contractor or volunteers understood the PREA training received. A review of the files reveals that there have been no volunteers or contractors employed in LLBTHFB in the last 12 months. *The facility is in compliance with this provision.*

Corrective Action Findings: None

This facility is in compliance with this standard.

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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. LL Brandon III RTC Zero Tolerance Policy
c. Zero Tolerance Posters
d. Resident Handbook
e. PREA Brochure and poster
f. Office of Juvenile Justice Resident PowerPoint Education Module
g. Resident Education Acknowledgement forms

Interviews included:

a. Administrative Assistant/PREA Coordinator
b. Intake Staff
c. Staff who perform risk screening for sexual victimization and abusiveness
d. Random Staff

Site Review / Observations:

a. Posters affixed in areas commonly used by residents such as:
    i. Residential Hallways A & B
    ii. Dining and common areas
    iii. Administration and lobby areas
    iv. Intake/Case Manager's office
b. PREA brochures available to residents

115.333 (a) The LLBTHFB Zero Tolerance Policy, states that "during the admissions/intake process the resident are provided, by LLBTHFB, 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 after being provided the appropriate PREA education information in the PREA brochure and in the Resident Handbook. The Safeguarding Your Sexual Safety video does address the following points:

- Resident rights to be free from sexual abuse and sexual harassment
- Their rights to be free from retaliation for reporting such incidents
- The agency's policies and procedures for responding to such incidents.

The LLBTHFB Administrative Assistant/PREA Coordinator did provide this auditor with the LLBTHFB Resident Handbook in English and Spanish. During the random resident interviews, 12 of 12 residents reported that this information was provided and explained to them upon intake. They further indicated that they understand the zero-tolerance policy and know how to report a sexual abuse and sexual harassment allegation.

Over the past twelve months 90 residents were admitted to LLBTHFB and all of the intake packets included an acknowledgement signed by each resident that they received and understood the zero-tolerance policy information. When reviewing resident files this auditor found no evidence that there were residents who did not receive the required Zero Tolerance Policy information. *The facility is in compliance with this provision.*

115.333 (b) The LLBTHFB Zero Tolerance Policy states that "within 10 days after admission, LLBTHFB provides comprehensive, age-appropriate education to resident about their rights to be free from sexual abuse, sexual harassment, and retaliation for reporting". Through the random resident interviews this auditor found evidence that 12 of 12 residents had not received PREA educational training, which should be presented in an age-appropriate manner, within 10 days of their intake.

This auditor did not receive copies of the resident acknowledgement statements as proof that the actual PREA education is being provided to residents within 10 days of their intake to inform the youth of:

- Their rights to be free from retaliation for reporting such incidents
- The agency's policies and procedures for responding to such incidents.

The facility is not in compliance with this provision.

115.333 (c) During the random resident interviews 12 of 12 residents interviewed indicated that they had not received the comprehensive education within 10 days of their intake. A review of the resident files indicated that all 12 residents acknowledged that they did not receive any comprehensive education within 10 days from intake. The resident files and the Administrative Assistant/PREA Coordinator further corroborated that they had not received this comprehensive education within 10 days after their intake.

During the intake staff interview this auditor asked how they ensured current residents as well as those transferred from other facilities were educated on the agency's Zero Tolerance Policy. She stated that regardless of how, when, or where a resident comes to the facility, they would be provided with the same comprehensive education about their rights to be free from sexual abuse, sexual harassment, retaliation and how to report a sexual abuse and sexual harassment allegation. *The facility is not in compliance with this provision.*

115.333 (d) The LLBTHFB intake staff did provide this auditor with the resident education in formats accessible to all residents at the facility during this audit, including materials translated into Spanish. This auditor was able to review a documented Memorandum of Agreement between LLBTHFB and the Shreveport Independent School District regarding the provision of providing resident services who are:

- Limited in English Proficient
- Visually impaired
- Otherwise disabled
- Having limited reading skills

The Administrative Assistant/PREA Coordinator indicated during her interview that Caddo Parish School Board's Booker T. Washington School would provide assistance to them in creating education materials in formats accessible for residents that are deaf, visually impaired, have limited reading skills, otherwise disabled or have limited reading skills. When intake staff were asked how residents with limited reading skills could benefit from the PREA related information, she responded that the staff would read the printed information to the resident with the limited reading skills, contact the Caddo Parish School Board's Booker T. Washington School for service to residents who have the above stated disabilities, and would instruct them on how they can call the 1-800 hotline number to report a sexual abuse and sexual harassment allegation. *The facility is in compliance with this provision.*

115.333 (e) The LLBTHFB Program Director/ Administrative Assistant/PREA Coordinator did not provide copies of the resident training rosters of the comprehensive education and signed acknowledgement statements from 12 of the 12 residents to indicate that they received and understood the PREA information. *The facility is not in compliance with this provision.*

115.333 (f) During the site review of the LLBTHFB this auditor did observe PREA posters in the residential areas of the facility. These posters did include the 1-800 phone number for reporting a sexual abuse and sexual harassment allegation as well as the name and phone number for seeking emotional support and crisis intervention. This auditor also received a copy of and reviewed the PREA information that is in the resident handbook.

The PREA brochures and Zero Tolerance flyers were observed during the site review in the lobby of the administration building, in both the common areas, and in each residential wing (unit) of the facility. *The facility is in compliance with this provision.*

This facility is not in compliance with this standard.

Corrective Action Findings: The facility needs to provide to this auditor a copy of the PREA educational module utilized to educate all residents, including to new residents, within 10 days of intake and signed acknowledgement forms from current and future residents attesting that they have received this education in order to be in compliance with this standard.

Corrective Action Response: The PREA Coordinator did provide signed acknowledgement statements from the current residents indicating that they have received the comprehensive PREA educational training. She did provide acknowledgement statements from those residents that entered the program during this post-audit period and signed acknowledgement forms that they received the comprehensive education within 10 days of intake. The facility is in compliance with this standard.

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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. LL Brandon III RTC Zero Tolerance Policy

Interviews included:

a. Executive Director
b. Administrative Assistant/PREA Coordinator
c. Random Staff
d. Staff on the Incident Review Team

Site Review / Observations:

a. None

115.334 (a) LLBTHFB Zero Tolerance Policy states that "LLBTHFB staff member are not qualified to investigate allegations of sexual abuse and sexual harassment". The Administrative Assistant/PREA Coordinator indicated during her interview that no one in her staff is qualified to conduct sexual abuse and sexual harassment investigations. These allegations are referred to either the Shreveport Police Department (LSP) for criminal investigations or to the Louisiana Office of Juvenile Justice for Administrative investigations. This provision is not applicable to this agency. *The facility is in compliance with this provision.*

115.334 (b) Because administrative and criminal investigations are the responsibility of Shreveport Police Department (SPD) and the Louisiana Office of Juvenile Justice (LOJJ) their 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. This provision is not applicable to this agency. *The facility is in compliance with this provision.*

115.334 (c) Because administrative and criminal investigations are the responsibility of Shreveport Police Department (SPD) and the Louisiana Office of Juvenile Justice (LOJJ) their staff are not required to provide documented proof that SPD and LOJJ personnel have received the required specialized training. This provision is not applicable to this agency. *The facility is in compliance with this provision.*

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

This facility is in compliance with this standard.

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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. LL Brandon III RTC Zero Tolerance Policy

Interviews included:

a. Administrative Assistant/PREA Coordinator
b. Executive Director

Site Review / Observations:

a. None

115.335 (a) The LLBTHFB Zero Tolerance Policy states that LLBTHFB ensures and maintains documentation that if employed, their full and part-time medical and mental health practitioners working in LLBTHFB operated facility they would 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 and sexual harassment.
4. How and to whom to report allegations of sexual abuse and harassment.

LLBTHFB does have a part time medical practitioner employed at the facility who has received training that addresses the following training topics:

- How to detect and assess signs of sexual abuse and sexual harassment
- How to preserve physical evidence of sexual abuse
- How to respond effectively and professionally to juvenile sexual abuse victims of sexual abuse and sexual harassment.
- How and to whom to report allegations or suspicion of sexual abuse and sexual harassment.

The facility is in compliance with this provision.

115.335 (b) LLBTHFB Human Resource staff indicated that they do employ a part time medical staff who is not required to receive training related to forensic exams. The part time medical staff stated during her interviewed that her responsibility is to provide medication maintenance, first aid and make doctor appointment or emergency room referrals as needed. She further stated that she is not training on how to conduct forensic examinations. *The facility is in compliance with this provision.*

115.335 (c) LLBTHFB Human Resource staff indicated that they do employ a part time medical staff who is not required to receive forensic examination training but who has received the employee PREA training. The PREA Coordinator and the part-time medical staff did corroborate this assertion. *The facility is in compliance with this provision.*

115.335 (d) LLBTHFB Human Resource staff indicated that the medical staff employed has received the required training as mandated by employees by 115.331 and 115.332. The PREA Coordinator and the part-time medical staff did corroborate this assertion *The facility is in compliance with this provision.*

This facility is in compliance with this standard

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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. LL Brandon III RTC Zero Tolerance Policy
c. Risk Screening Intake Instrument

Interviews included:

a. Executive Director
b. Administrative Assistant/PREA Coordinator
c. Intake Staff
d. Random Resident

Site Review / Observations:

a. None observed.

115.341 (a) The LLBTHFB Zero Tolerance Policy states that "LLBTHFB does use an objective screening instrument within 72 hours after a resident's admission to LLBTHFB to obtain information about the resident's personal history and behavior to reduce the risk of sexual abuse by or upon another resident". Upon file review of the residents file, this auditor randomly selected 12 resident files and found that 100% of these files did not have an objective risk screening completed within the 72-hour time period. The risk screening instrument being utilized by LLBTHFB was not comprehensive enough to capture all of the relevant information required of this standard. Upon further review it was ascertained that LLBTHFB does not periodically obtain information throughout a resident's stay in this facility. *The facility is not in compliance with this provision.*

115.341 (b) LLBTHFB Zero Tolerance Policy states that "periodically throughout the resident's stay, information from the screening instrument is used to reassess housing and supervision assignments". The Intake staff indicated during her interview that residents are not provided a periodic screening assessment during their stay to assess housing and supervision assignments. *The facility is not in compliance with this provision.*

115.341 (c) The current screening instrument used at LLBTHFB, does not attempt to 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; and
11. Any specific information about individual residents that may indicate heightened need for supervision, additional safety precautions, or separation from certain residents.

During the interview with the Intake staff, it was ascertained that some information was not being captured and or asked during the risk screening i.e., number 3, 5, 7, 8, 9, and 10 as required from this provision. *The facility is not in compliance with this provision.*

115.341 (d) This auditor ascertained through the resident file audit and the Intake staff interview that the risk assessments are not being conducted through conversation with the resident during the intake, classification process; from the mental health screenings, from reviewing court records and other relevant documentation. Documentation of the intake screening but not a risk assessment was provided to this auditor. *The facility is not in compliance with this provision.*

115l341 (e) The Administrative Assistant/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. This information is controlled by double locking the paper files in a file cabinet of the case manager's office, electronic files are password protecting the electronic records and only authorized employees are permitted to view the protected information on a need-to-know basis. During the site review this auditor was able to review these files in the case manager's office, where they were stored. *The facility is in compliance with this provision.*

Recommendation: This auditor recommends that LLBTHFB Intake staff create an objective risk assessment instrument and a risk reassessment instrument to periodically assess a resident every 90 days of their stay Utilization of the artifact provided and discussed during debriefing will assist in this endeavor.

This facility is not in compliance with this standard.

Corrective Action Findings: This facility needs to develop an objective risk screening instrument to include elements 1 through 11 of this Standard, as well as begin conducting periodic reassessments of the residents during their stay at LLBTHFB. Proof documentation over the next 3 months to ensure the institutionalization of this practice must be provided to this auditor for his review, in order to be in compliance with this standard.

Corrective Action Response: The PREA Coordinator did provide to this auditor an objective risk screening instrument to assess the residents upon intake and periodically during their stay in the facility. She also provided copies of the completed risk screening reassessment instrument utilized on current residents who have been at the facility at least 90 days, to assess these resident every 90 days for risk of sexual abuse and sexual harassment. The facility is in compliance with this standard.

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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. LL Brandon III RTC Zero Tolerance Policy
c. Risk Screening Assessment Tool
d. Resident Files

Interviews included:

a. Executive Director
b. Administrative Assistant/PREA Coordinator
c. Intake Staff
d. Random Residents

Site Review / Observations:
a. Facility Site Review - No isolation Rooms were observed.

115.342 (a) LLBTHFB's Zero Tolerance Policy states that LLBTHFB "uses all information obtained during intake screening to make housing, bed, program, education, and work assignments for resident". The Intake staff as well as the Administrative Assistant/PREA Coordinator confirmed in their interviews

that information learned during the intake screening is not used to make informed housing assignments. Furthermore, the housing assignments are only discussed when there is an incident and moving residents to another bedroom, work educational or program assignment with the goal of keeping them safe from sexual abuse and sexual harassment will be considered. *The facility is not in compliance with this provision.*

115.342 (b) The LLBTHFB Zero Tolerance Policy prohibits the use of isolation, therefore LLBTHFB avoids isolating residents due to risk of sexual victimization. During the onsite audit this auditor walked freely throughout the facility and was given access to all areas as requested. This facility never places residents in isolation nor is the facility designed for such according to the facility's schematics. *The facility is in compliance with this provision.*

115.342 (c) LLBTHFB Administrative Assistant/PREA Coordinator and the Intake staff indicated during their interview that LLBTHFB does not place Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) residents in a particular house, bed, or other assignment solely on the basis of such identification. LLBTHFB reported on the PAQ of having zero LGBTI resident in the 12 months. The Administrative Assistant/PREA Coordinator indicated during her interview that if an LGBTI resident were in the program that LLBTHFB would always refrain from considering lesbian, gay, bisexual, transgender, or intersex (LGBTI) identification or status as an indicator or likelihood of being sexually abusive. *The facility is in compliance with this provision.*

115.342 (d) LLBTHFB is an all-male facility. The Intake Staff and the PAQ reported no LGBTI residents in the past 12 months. The Intake staff stated in her interview that the housing assignments would be made on a case-by-case basis and as with all resident the assignment would be based on ensuring the residents health and safety, and whether placement would present management or security problems. LLBTHFB reported on the PAQ of having zero transgender and intersex residents in the facility during the last 12 months. *The facility is in compliance with this provision.*

115.342 (e) At the time of this audit and in the last 12 months LLBTHFB reported that there were no residents who identified as transgender or intersex at the facility. LLBTHFB Zero Tolerance Policy, (pg.8) does state that "transgender and intersex resident housing assignments and programing assignments would be reassessed at least twice each year to review any threats to safety experienced by the resident" LLBTHFB reported on the PAQ of having zero transgender and intersex resident in the 12 months. *The facility is in compliance with this provision.*

115.342 (f) LLBTHFB Zero Tolerance Policy states that LLBTHFB "would give serious consideration to the resident's own views concerning their safety when making placement and programming assignments" for a transgender or intersex resident. LLBTHFB reported on the PAQ of having zero transgender and intersex residents in the 12 months. *The facility is in compliance with this provision.*

115.342 (g) LLBTHFB's Zero Tolerance Policy states that it would (h) (I) "provides the opportunity for all residents to shower separately". During the facility site review its auditors observed single bedroom with private bathroom and the shower areas which are behind a locked door for complete resident privacy. LLBTHFB reported on the PAQ of having zero transgender and intersex residents in the 12 months. *The facility is in compliance with this provision.*

115.342 (h) LLBTHFB never places residents in isolation nor is the facility designed for such according to the facility's schematics. *The facility is in compliance with this provision.*

115.342 (I) This facility never places residents in isolation nor is the facility designed for such according to the facility's schematics. *The facility is in compliance with this provision.*

This facility is not in compliance with this standard.

Corrective Action Findings: This facility needs to develop an objective risk reassessment screening instrument to include elements 1 through 11 of this Standard as well as begin conducting periodic reassessments of the residents during their stay at LLBTHFB. Proof documentation over the next 3 months to ensure the institutionalization of this practice must be provided to this auditor for his review, in order to be in compliance with this standard.

Corrective Action Response: The PREA Coordinator did provide to this auditor a copy of the developed objective risk screening instrument to assess the residents upon intake and periodically during their stay in the facility. She also provided a copy of the risk screening reassessment instrument utilized to assess the current residents every 90 days. The facility is in compliance with this standard.

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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. LL Brandon III RTC Zero Tolerance Policy
c. Resident Files
d. Grievance Policy and Form
e. Resident Handbook
f. Memorandum for Resident Reporting
g. Incident Report Form
h. PREA Poster

Interviews included:

a. Executive Director
b. Administrative Assistant/PREA Coordinator
c. Intake Staff
d. Random staff
e. Designated Staff to Monitor for Retaliation
f. Random Residents

Site Review / Observations:

a. Facility Site Review
b. Location of “Red Phones” for reporting an allegation

115.351 (a) LLBTHFB Zero Tolerance Policy states that LLBTHFB “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 LLBTHFB Zero Tolerance Policy lists the following ways to report:

(I) Submitting a written grievance, verbally or by any means the resident has access to;
(ii) Calling the LaFASA 24-hour toll free hotline 1 888-995-7273 without being heard by staff or other residents;
(i) Telling any staff member, volunteer, or contract employee who must then call the hotline and inform the PREA Coordinator and the Executive Director; or
(ii) Calling the toll-free number maintained by the Louisiana Office of Juvenile Justice (LOJJ), 1-800-626-1430, which is a separate state agency. Also, without being heard by staff or residents.

a) During the interviews with the random residents, they all indicated their knowledge of reporting a sexual abuse and sexual harassment, retaliation or staff neglect allegations by either telling a staff member, write a grievance or call the LOJJ’s anonymous number that is listed on the PREA poster. This auditor observed in throughout the facility the PREA poster displaying the LOJJ and La FASA’s number that a resident can call to report a sexual abuse and sexual harassment allegation or incident. During the random staff interviews they all indicated the ways a resident can report a sexual abuse and sexual harassment allegation by informing them, writing a grievance, calling the 1800 number or the LOJJ or La FASA’s number. The Administrative Assistant/PREA Coordinator stated that the “red phones”, though not installed as of the onsite visit, are to be located on each unit (wing) for the resident to utilize when making a 1-800 number when reporting a sexual abuse or sexual harassment allegation. Currently, they have access to the phone in the case manager’s office to make these calls if necessary.
b) The PREA Coordinator did provide pictures of the installed “red phones” and their location during the post audit period.

The facility is in compliance with this provision.

115.351 (b) LLBTHFB Zero Tolerance Policy states that “a residents may call the toll-free number maintained by the Louisiana Office of Juvenile Justice (LOJJ), 1 (800) 626-1430, which is a state agency to report a sexual abuse, sexual harassment, retaliation or staff neglect allegation. The Administrative Assistant/PREA Coordinator stated that the “red phones”, though not installed, are to be located on each unit (wing) for the resident to utilize when making a 1-800 number when reporting a sexual abuse or sexual harassment allegation. Currently, they have access to the phone in the case manager’s office to make these calls if necessary.

LOJJ, according to the Administrative Assistant/PREA Coordinator, does receive and immediately forwards these allegation calls to the Executive Director. The LOJJ hotline operator confirmed this procedure. During the random resident interviews each one indicated that they could make this call in a private area like the case manager’s office, without being heard by the staff or other residents and could remain anonymous upon request.

The Administrative Assistant/PREA Coordinator did provide to this auditor during the pre-audit phase a memorandum from the Executive Director stating that within the last 12 months no residents have been

housed in this facility solely for immigration purposes. She also indicated such during her interview and on the PAQ provided. *The facility is in compliance with this provision.*

115.351 (c) LLBTHFB Zero Tolerance Policy states that staff will "promptly accepts verbal and written reports made anonymously or by third parties and promptly document any verbal reports". During the interview with the random staffs when asked this question, each staff stated that they would accept verbal reports of sexual abuse and sexual harassment verbally, in writing, anonymously, from third parties and would document them immediately on the agency's indicant report form. A copy of the facility's incident report form was not provided to this auditor during the pre-audit phase. *The facility is in compliance with this provision.*

115.351 (d) LLBTHFB Zero Tolerance Policy states that LLBTHFB "provides residents access to grievance forms, writing instruments, to privately make a written report". During the interview with the random residents, they all indicated that they have access to paper, pencils and grievance forms if they want to report a sexual abuse and sexual harassment allegation in writing. This auditor was provided with a blank grievance form during the pre-audit phase. While on the site review this auditor observed the availability of grievance forms and pencils for the resident's usage. During the interviews with the random staff, they all indicated that they could report a sexual abuse, sexual harassment, and retaliation allegation against a resident privately by going to the case manager's office in person, calling them on the phone, calling the 1 800 numbers or by writing a note or grievance. *The facility is in compliance with this provision.*

This facility is in compliance with this standard.

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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. LL Brandon III RTC (LLBTHFB) Zero Tolerance Policy
c. Resident Handbook
d. Grievance Policy and Form
e. Resident File review
f. Third Party Reporting Form
g. Memorandum on Exhaustion on Administrative Remedies

Interviews included:

a. Executive Director
b. Administrative Assistant/PREA Coordinator
c. Intake Staff
d. Random Staff
e. Random Residents

Site Review / Observations:

a. Agency website: www.info@northwestlouisianacdc.org

115.352 (a) This standard does apply to LLBTHFB because they do have administrative procedures to address all resident grievances and does have an administrative remedy process to address sexual abuse. *The facility is in compliance with this provision.*

115.352 (b) LLBTHFB Zero Tolerance Policy states that LLBTHFB "investigates all allegations of sexual abuse regardless of how much time has passed since the alleged incident". Furthermore, the Zero Tolerance policy states that "residents are not required to use the grievance system or the informal conference request system to report an allegation of sexual abuse and are not required to attempt to resolve the allegation with staff". During the interviews with the Executive Director and the Administrative Assistant/PREA Coordinator, they corroborated this policy statement as a practice of refraining from requiring a resident to use any informal grievance process in an attempt to resolve with a sexual abuse or sexual harassment allegation with staff member. The Intake staff stated during her interview that all residents, during Intake, are verbally informed of this procedure. During several of the resident interviews they stated that if they had a grievance that they would seek resolution first with a staff member, then with the supervisor, then with the Executive Director. A review of the resident's handbook does not reflect the procedure of instructing the resident that they are not required to use the grievance system to report an allegation of sexual abuse or the informal conference request system to resolve the allegation with staff. *The facility is not in compliance with this provision.*

115.352 (c) LLBTHFB Zero Tolerance Policy states 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 and that such grievances are not referred to a staff member who is the subject of a complaint". During the interviews with the Administrative Assistant/PREA Coordinator and the Executive Director both corroborated this policy statement as a practice of refraining from requiring a resident to use any informal grievance process in an attempt to resolve with a sexual abuse or sexual harassment allegation with staff member. The Intake staff stated during her interview that all residents during Intake

are verbally informed of this procedure. A review of the resident's handbook does not reflect the procedure of instructing the resident that they are not required to submit the complaint to a staff member who is the subject of a complaint". *The facility is not in compliance with this provision*.

115.352 (d) The Administrative Assistant/PREA Coordinator indicated during her interview that the agency does 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. She also acknowledged that if they determined that the 90-day timeframe is insufficient that she would make an appropriate decision, claim an extension of time of not more than 70 days, and notify the resident in writing of any such extension and provide a date by which a decision will be made. She further stated that if the resident does not receive a response, they could consider the absence of a response to be a denial at that level and can then pursue outside ligation. During the interviews of the random residents, random staff, and a review of the grievances of the past 12 months, this auditor found zero grievances for sexual abuse or sexual harassment. *The facility is in compliance with this provision.*

115.352 (e) LLBTHFB Zero Tolerance Policy states that LLBTHFB "accepts verbal and written reports made anonymously or by third parties and promptly documents verbal reports". During the random staff interviews they all stated that they would receive and document all verbal allegations of sexual abuse and sexual harassment promptly. LLBTHFB does not publicly distribute information on the agency's website for third party report. *The facility is not in compliance with this provision.*

According to LLBTHFB'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 not observed nor made available to the public on the agency's website and the forms were not provided to this auditor during the pre-audit phase. The Administrative Assistant/PREA Coordinator indicated during her interview that third parties are permitted to file such requests on behalf of residents, if a resident were to decline to have a third-party request processed on his behalf, that LLBTHFB would document the resident's decision. She further stated that LLBTHFB accepts third party allegations and grievances from anyone, this includes appeals on behalf of the resident, from a parent or legal guardian and that no grievance would be conditioned upon the resident agreeing to have a request filed on his behalf. She also stated that there were no third-party allegations of sexual abuse and sexual harassment reported in the last 12 months. *The facility is not in compliance with this provision.*

115.352 (f) LLBTHFB has an open-door policy to the Executive Director, the Administrative Assistant/PREA Coordinator and the Case Manager's offices where a resident can file an emergency grievance alleging that they are subject to a substantial risk of imminent sexual abuse. During the interviews with the random staff, they all responded that if a resident submitted an emergency grievance or approached them indicating that they are at risk of imminent sexual abuse that they would take immediate action to keep the youth safe and immediately contact their supervisor. The Executive Director, the Administrative Assistant/PREA Coordinator and the Case Manager's all corroborate this assertion. It was observed during the site review and throughout the onsite audit that LLBTHFB's administrative staff do maintain constant communication with their direct care staff and residents. That any grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, would be immediately reviewed at the highest level of the facility and then would be forwarded to Louisiana Office of Juvenile Justice (LOJJ) and to the Shreveport Police Department (SPD) for investigating. All the staff interviewed mentioned the separating of a resident from an imminent risk of sexual abuse. *The facility is in compliance with this provision.*

The Administrative Assistant/PREA Coordinator also indicated during her interview that after receiving an emergency grievance, that she or the Executive Director would provide an initial response to the resident within 48 hours. Because LLBTHFB does not conduct any investigations and any grievance related to sexual abuse and sexual harassment would be forwarded to the Shreveport Police Department (SPD) and the Louisiana Office of Juvenile Justice (LOJJ) since they are not exempt from this provision of issuing a final decision within 5 calendar days. The Administrative Assistant/PREA Coordinator stated that they would provide to the resident, after the initial response to their emergency grievance, a final decision as to whether the resident is in substantial risk of imminent sexual abuse. *The facility is in compliance with this provision.*

115.352 (g) LLBTHFB's Zero Tolerance Policy states 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 LLBTHFB Executive Director and Administrative Assistant/PREA Coordinator indicated during their interviews that no resident had been disciplined for filing any grievance in bad faith. A review of the grievances filed over the past 12 months revealed that there were zero grievances alleging sexual abuse or sexual harassment. During the interviews the random residents they all reported feeling safe at LLBTHFB and that they could file a sexual abuse or sexual harassment allegation without fear of retaliation. *The facility is in compliance with this provision.*

The facility is not in compliance with this standard.

Corrective Action Findings: LLBTHFB must create a third-party form, post it on the agency's website or other public venue for public review and usage, and update the Resident Handbook to include the following statement" "residents are not required to use the grievance system or the informal conference request system to report an allegation of sexual abuse or sexual harassment and are not required to attempt to resolve the allegation with the staff member who is the subject of the complaint". They must then send the update section to the handbook, create a third-party form and inform him as to where it will be posted for this auditor's review, in order to be in compliance with this standard.

Corrective Action Response: The PREA Coordinator did provide to this auditor for his review the created third-party form, indicated that it was posted in the facility's lobby display case for public view, that the form is made available to any person requesting to file a 3rd party report on behalf of a resident and she did provide a update to the Resident Handbook that included the following statement" "residents are not required to use the grievance system or the informal conference request system to report an allegation of sexual abuse or sexual harassment and are not required to attempt to resolve the allegation with the staff member who is the subject of the complaint". The facility is in compliance with this standard.

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 assessable 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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. LL Brandon III RTC (LLBTHFB) Zero Tolerance Policy
c. Memorandum of Understanding with Project Celebration

d. Zero Tolerance PREA Posters
e. Facility Schematics
f. Resident Handbook

Interviews included:

a. Executive Director
b. Administrative Assistant/PREA Coordinator
c. Intake Staff
d. Random Staff
e. Random Residents

Site Review / Observations:

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

115.353 (a) The LLBTHFB Zero Tolerance Policy states how all residents have "access to outside confidential support services related to sexual abuse and harassment. LLBTHFB also provides residents with access to representatives of such local, State, or national victim advocacy or rape crisis organizations". LLBTHFB does not detained residents solely for civil immigration purposes, therefore no postings or brochures include contact information for immigration services is required.

The Administrative Assistant/PREA Coordinator stated that the "red phones", though not installed, are to be located on each unit (wing) for the resident to utilize when making a 1-800 number when reporting a sexual abuse or sexual harassment allegation. Currently, they have access to the phone in the case manager's office to make these calls if necessary. During the interview with the random resident, 12 of 12 residents confirmed that they believe that their call to an outside support services provider would be private and confidential. During the interview with the random staff, 12 of 12 staff interviewed confirmed that residents would be provided a private space to make a confidential phone call any of the agencies listed upon request.

This auditor observed during the site review in the houses the following phone numbers posted on the bulletin board:

- Louisiana Office of Juvenile Justice Hotline 1-800-626-1430
- LaFASA 24-hour Crisis Hotline 1-888-995-7273
- Project Celebration 1-888-411-1333

During the interview with the Intake staff, she indicated that residents are also provided with information about Louisiana Office of Juvenile Justice's Hotline number and brochure. The LaFASA representative reported that there were no calls on record from LLBTHFB in the past 12 months requesting their services. *The facility is in compliance with this provision.*

115.353 (b) The Intake staff indicated during her interview that the residents are informed during intake the extent to which communications with these agencies will be monitored and the extent to which reports of sexual abuse being reported to them will be forwarded to the authorities in accordance to mandatory reporting laws. During the interviews with the random staff, they all reported that they are mandated to report of sexual abuse and sexual harassment by state law and have received training on such. The intake staff and Administrative Assistant/PREA Coordinator interviewed acknowledged that the residents are informed of the mandatory reporting rules governing privacy, confidentiality, and/or

privileges that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant Federal, State, or local law. The Intake staff indicated that verbal notification would be provided to the resident before discussing sexual abuse and sexual harassment allegation with the residents. LLBTHFB random staff and management confirmed during their respective interviews that the resident's phone calls are not monitored or recorded. *The facility is in compliance with this provision.*

115.353 (c) LLBTHFB did not provide a copy of the Memorandum of Understanding with the Project Celebration during the pre-audit phase that provide residents with confidential, emotional support and victim services related to sexual abuse and sexual harassment. Project Celebration provide emotional support services to members of the public, including residents of LLBTHFB, free of charge and can also be provided in-person or by phone. *The facility is not in compliance with this provision.*

115.353 (d) LLBTHFB's Zero Tolerance Policy states that LLBTHFB "does provide residents with reasonable and confidential access to their attorneys or legal representation, parents, and legal guardians". During the site review this auditor observed the area that is used for parental and legal visits. Parents, guardians and attorneys have reasonable access to the residents by contacting the facility to schedule a visit. During the random resident interviews each one explained that they could meet with their legal representatives, parents, and legal guardians in a confidential manner in the facility if required or requested by either party. *The facility is in compliance with this provision.*

This facility is not in compliance with this standard.

Corrective Action Findings: The Administrative Assistant/PREA Coordinator must provide a copy of the Memorandum of Agreement or written attempts of the same, to this auditor for his review that they have entered into with Project Celebration to provide the emotional support and crisis counseling to victims of sexual abuse in order to be in compliance with this standard.

Corrective Action Response: The Administrative Assistant/PREA Coordinator did provide a copy of a memorandum from the Executive Director, to this auditor, indicating that they have attempted to entered into an agreement with Project Celebration who would provide the emotional support and crisis counseling to victims of sexual abuse. She further stated that she has been in verbal communication with a representative who indicated that Project Celebration would provide these services but have not been able to obtain this agreement in writing. The facility is in compliance with this standard.

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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. LL Brandon III RTC Zero Tolerance Policy
c. Zero Tolerance PREA Posters
d. 3rd Party Reporting Form

Interviews included:

a. Executive Director
b. Administrative Assistant/PREA Coordinator
c. Random Residents
d. Random Staff

Site Review / Observations:

a. Zero Tolerance Postings
b. Availability of Third-Party Reporting forms.
c. Agency Web Site: www.info@northwestlouisianadevelopment.org

115.354 The LLBTHFB Zero Tolerance Policy does describes the procedures to receive and for making a 3rd party report of sexual abuse and harassment on behalf of a resident. This auditor not did observe the link regarding 3rd party reporting procedure on the agency's website nor posting in the facility's display case for public viewing. The Administrative Assistant/PREA Coordinator did provide a copy of the 3rd party reporting form during the pre-audit phase. She reported that there have been no 3rd party grievances of sexual abuse and harassment on behalf of a resident in the last 12 months. *The facility is not in compliance with this provision.*

This facility is not in compliance with this standard.

Corrective Action Findings: LLBTHFB must update the agency's website and or the facility's display case to include the 3rd party reporting form for the public's access and or to provide directions for third party individuals on how to file a complaint or report an allegation of sexual abuse or sexual harassment on behalf of a resident. The facility must inform this auditor when this information has been added to the agency's website for his review and verification in order to be in compliance with this standard.

Corrective Action Response: The PREA Coordinator did provide to this auditor pictures of the facility's display case in the lobby that reflects the posting of the 3rd party reporting form for the public's access, pending upload to their website, which that provides directions for third party individuals on how

to file a complaint or report an allegation of sexual abuse or sexual harassment on behalf of a resident. The facility is in compliance with this standard.

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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. LL Brandon III RTC Zero Tolerance Policy
c. Zero Tolerance PREA Posters
d. 3rd Party Reporting Form
e. Memorandum on Agency Protection Duties
f. Employee's Mandatory Reporter Training Certificates

Interviews included:
a. Executive Director
b. Administrative Assistant/PREA Coordinator
c. Random Residents
d. Random Staff
e. Intake Staff

Site Review / Observations:

a. Zero Tolerance PREA Poster postings

115.361 (a) LLBTHFB's Zero Tolerance Policy does state that all staff "must immediately report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment, retaliation against residents or staff who reported an incident any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation whether or not it is part of the agency".
During the interviews with the random staff, they all indicated that they had a duty to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment, retaliation against residents or staff who reported an incident any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation. *The facility is in compliance with this provision.*

115.361 (b) LLBTHFB Zero Tolerance Policy states that "all staff must comply with any applicable mandatory child abuse reporting laws in Louisiana Family Code and other applicable professional licensure requirements". During the interviews with the random and specialized staff they all indicated that they are mandated by law to report sexual abuse allegations against a resident to the facility, to LOJJ and to SPD *The facility is in compliance with this provision.*

115.361 (c) LLBTHFB Zero Tolerance Policy states 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". During the interviews with the random staff, they all indicated that they would not inform other staff of an incident of sexual abuse or sexual harassment against a resident other than the extent necessary to make treatment, investigation and other security and management decisions. *The facility is in compliance with this provision.*

115.361 (d) LLBTHFB does not have any medical or mental health practitioners but the Executive Director and Administrative Assistant/PREA Coordinator both reported that if they employed such practitioners that they would be required to any report sexual abuse allegation to a supervisor, or the Executive Director, pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws. They further stated that would be required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services provided. *The facility is in compliance with this provision.*

115.361 (e) Upon receiving any allegation of sexual abuse, the Executive Director and the Administrative Assistant/PREA Coordinator both stated during their interviews that they would promptly report an allegation of sexual abuse to the Louisiana Office of Juvenile Justice (LOJJ), to the Shreveport Police Department (SPD), the parents, guardians of the resident, and if on probation, to the juvenile court of jurisdiction including the probation officer and the resident's attorney of record.*The facility is in compliance with this provision.*

115.361 (f) LLBTHFB does not have facility designated investigators so all allegations of sexual abuse and sexual harassment, including 3rd party reports, are immediately reported to LOJJ and the SPD which are the designated investigation agencies. *The facility is in compliance with this provision.*

This facility is in compliance with this standard

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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. LL Brandon III RTC Zero Tolerance Policy
c. Memorandum for Agency Protection Duties

Interviews included:

a. Executive Director
b. Administrative Assistant/PREA Coordinator
c. Random Residents
d. Random Staff
e. Intake Staff

Site Review / Observations:

a. Agency's website: www.info@northwestlouisianacdc.org.

115.362 (a) LLBTHFB Zero Tolerance Policy states that "upon receipt a resident is subject to a substantial risk if imminent sexual abuse, LLBTHFB staff shall take immediate action to protect the youth". During the interviews of the random staff and specialized staff they all described their responsibility and understanding that when they learn that a resident is subject to a substantial risk of imminent sexual abuse, that they must take immediate action to protect the resident. Because the facility does not utilize isolation, keeping the resident safe means separating the alleged victim from the alleged perpetrator, making housing reassignment, providing one on one supervision, and or remove the other person who is causing the imminent risk of sexual abuse or sexual harassment from the

facility, according to the Administrative Assistant/PREA Coordinator. *The facility is in compliance with this provision.*

This facility is in compliance with this standard.

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*)

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

a. PREA Audit Questionnaire (PAQ)
b. LL Brandon III RTC Zero Tolerance Policy

c. Memorandum on Reporting to other Confinement Facilities

Interviews included:

a. Executive Director
b. Administrative Assistant/PREA Coordinator
c. Intake Staff

Site Review / Observations:

a. None

115.363 (a) The LLBTHFB Zero Tolerance Policy does state that LLBTHFB must immediately notify the agency head of the facility or appropriate office of the agency where the abuse occurred and that the head of the facility that receives the allegation would also notify the appropriate investigative agency." The Administrative Assistant/PREA Coordinator and the Executive Director stated during their interview that she had not received an allegation from a resident during intake alleging that they were sexually abused at another facility in the last 12 months. She further stated that if she would have received one that upon receiving an allegation would notify LOJJ immediately and then the head of the facility or appropriate office of the agency where the alleged abuse occurred. *The facility is in compliance with this provision.*

115.363 (b) The Executive Director stated during his interview that he would make notification to the head of the facility where the abuse allegedly occurred within 72-hours after receiving the allegation. The Executive Director stated during his interview that he had not received an allegation from a resident during intake alleging that they were sexually abused at another facility in the last 12 months. *The facility is in compliance with this provision.*

115.363 (c) The Executive Director stated during his interview that he would document the notification of sexual abuse related to another facility and maintain a record of it. The Executive Director stated during his interview that he had not received an allegation from a resident during intake alleging that they were sexually abused at another facility in the last 12 months *The facility is in compliance with this provision.*

115.363 (d) The Executive Director indicated during his interview that although there has not been an allegation made in the last 12 months, that he, during the notification process to the facility's head, would ask the facility head to ensure that it be investigated according to this standard. *The facility is in compliance with this provision.*

This facility is in compliance with this standard.

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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. LL Brandon III RTC Zero Tolerance Policy
c. Employee Training Records
d. LLBTHFB First Responder's Duties

Interviews included:
a. Executive Director
b. Administrative Assistant/PREA Coordinator
c. Random Staff
d. First Responder Staff

Site Review / Observations:

a. None

115.364 (a) LLBTHFB Zero Tolerance Policy states that " upon learning a resident was sexually abused, the first staff member to respond to the report is required to separate the alleged victim and abuser, preserve and protect any crime scene until appropriate steps can be taken to collect any evidence and 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". During the interviews with the all of the random staff and first responders, they all indicated that they would separate the alleged victim and alleged abuser, preserve, protect the crime scene and evidence, and instruct the alleged victim and abuser not to take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. *The facility is in compliance with this provision.*

115.364 (b) The Administrative Assistant/PREA Coordinator stated during her interview that all LLBTHFB staff, including non-security staff, are trained as first responders and have the responsibility to separate the alleged victim from imminent risk, request that the alleged victim not take any actions that could destroy physical evidence as stated above, and then report the incident per policy to the Executive Director. *The facility is in compliance with this provision.*

The facility is in compliance with this standard.

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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)

b. LL Brandon III RTC Zero Tolerance Policy
c. Employee Training Records
d. LLBTHFB Response Plan

Interviews included:

a. Executive Director
b. Administrative Assistant/PREA Coordinator
c. Random Staff
d. First Responder Staff

Site Review / Observations:

b. None

115.365 (a) The LLBTHFB Zero Tolerance Policy does state that they "will maintain a written plan to coordinate the actions taken among first responders, mental health staff, administrators, and leadership". The Administrative Assistant/PREA Coordinator stated during her interview that she has developed and implemented the facility's coordinated response plan in writing. The Executive Director corroborated this policy requirement during his interview. During the pre-audit phase the Administrative Assistant/PREA Coordinator also provided this auditor a copy of their written response plan in response to a sexual abuse allegation. During the interviews with the random and first responder staff they all described the responsibilities direct care and management staff in the event of a sexual abuse or sexual harassment allegation e.g., contact a supervisor, contact law enforcement who would transport the sexual abuse victim to the hospital, etc. in accordance to the written response plan. *The facility is in compliance with this provision.*

The facility is in compliance with this standard.

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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. LL Brandon III RTC Zero Tolerance Policy
c. Employee Records
d. Contractual Agreement with the Louisiana Office of Juvenile Justice (LOJJ) Scope of Work

Interviews included:

a. Executive Director
b. Administrative Assistant/PREA Coordinator
c. Random Staff
d. Random Resident

Site Review / Observations:

a. None

115.366 (a) LLBTHFB Zero Tolerance Policy states that LLBTHFB "shall not enter into any agreement that limits its ability to remove alleged staff sexual abusers from contact with a resident pending the outcome of an investigation or determination of whether and to what extent discipline is warranted". The Administrative Assistant/PREA Coordinator indicated during her interview that LLBTHFB does not employ unionized employees therefore they do not participate in collective bargaining and that she can remove an alleged sexual abuser from having contact with residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted. *The facility is in compliance with this provision.* Upon review of the employee's files there was no indication that if discipline was warranted, including removing an alleged sexual abuse staff member from contact with a resident, that LLBTHFB was prevented from doing so due to a collective bargaining agreement. A review of the contractual agreements with the Louisiana Office of Juvenile Justice reflects that it does not prevent LLBTHFB from removing an alleged staff sexual abuser from contact with a resident pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted. *The facility is in compliance with this provision.*

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

This facility is in compliance with this standard.

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*)

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

Documents reviewed included:

a. LLBTHFB Zero Tolerance Policy
b. PREA Audit Questionnaire (PAQ)
c. Employee Files
d. Resident Files
e. Memorandum on Agency Protection Against Retaliation

Interviews included:

a. Executive Director
b. Staff Responsible for Monitoring Retaliation
c. Administrative Assistant/PREA Coordinator
d. Random Staff
e. Random Resident

Site Review / Observations:

a. None

115.367(a) LLBTHFB Zero Tolerance Policy states that "retaliation by a resident against a residents and staff member who report sexual abuse or sexual harassment or cooperate with an investigation is strictly prohibited". The Administrative Assistant/PREA Coordinator stated during her interview that she and each shift supervisor are the staff designated to monitor for retaliation. They are the staff designated to monitoring retaliation against staff or residents that report sexual abuse or harassment. *The facility is in compliance with this provision.*

115.367(b) LLBTHFB Zero Tolerance Policy states that states they "will use multiple protection measures to protect the resident and staff from retaliation, such as housing transfers, removal of the alleged abuser from contact with the alleged victim, 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 interview with the staffs designated to monitor for retaliation they all indicated that they would protect the victim by reassigning the alleged abuser to another (wing) unit, remove an alleged staff abuser or place them on administrative leave and would provide emotional support services for resident or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with an investigation. *The facility is in compliance with this provision.*

115.367(c) LLBTHFB Zero Tolerance Policy states that " for at least 90 days (except when the allegation is unfounded), the designated staff members would monitor the reporter and the alleged victim for signs of retaliation including items such as conduct and treatment of the resident or staff who reported the sexual abuse to see if there are any changes to suggest possible retaliation by residents or staff disciplinary reports, housing or program changes, staff reassignments, negative performance reviews and conducts periodic status checks on the alleged victim". During the interviews with the Administrative Assistant/PREA Coordinator and the designated to monitor for retaliation, they all indicated that they would also monitor in all of the areas as stated above to protect the staff or resident who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with an investigation. They further stated that for at least 90 days following a report of sexual abuse that they would monitor the resident program changes, the reassignment of staff and would continue the monitoring beyond 90 days if the initial monitoring indicates a continuing need. LLBTHFB did not report any monitoring of residents or staff for retaliation in the last 12 months. *The facility is in compliance with this provision.*

115.367(d) LLBTHFB Zero Tolerance Policy states that they would "conduct periodic status checks on the alleged victim". During the interview with the Administrative Assistant/PREA Coordinator and the designated staff to monitor for retaliation, they all indicated that they would conduct period status checks on the alleged victim daily. LLBTHFB did not report any monitoring of residents or staff for retaliation in the last 12 months. *The facility is in compliance with this provision.*

115.367 (e) LLBTHFB Zero Tolerance Policy states that "if any other individual cooperates with an investigation expresses fear of retaliation, they would take appropriate measures to protect that

individual against retaliation". During the interview with the Administrative Assistant/PREA Coordinator and the designated staff to monitor for retaliation, they all indicated that if any other individual who cooperated with an investigation expresses fear of retaliation, that they would take appropriate measures to protect them also against retaliation. LLBTHFB did not report any monitoring of residents or staff for retaliation in the last 12 months. *The facility is in compliance with this provision.*

115.367(f) Auditor is not required to audit this provision.

This facility is in compliance with 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*)

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

Documents reviewed included:

a. LLBTHFB Zero Tolerance Policy
b. PREA Audit Questionnaire (PAQ)
c. Facility Schematics of LLBTHFB
d. PREA Incident Reports
e. Resident Files
f. Memorandum for Post Allegation Protective Custody

Interviews included:
a. Executive Director
b. Administrative Assistant/PREA Coordinator
c. Random Staff
d. Random Residents

Site Review / Observations:

a. Site review of LLBTHFB

115.368 (a) LLBTHFB Zero Tolerance Policy states that "LLBTHFB does not use segregated housing to protect a resident who is alleged to have suffered sexual abuse". The Administrative Assistant/PREA Coordinator and the designated staff assigned to monitor against retaliation all stated during their interviews that LLBTHFB does not use segregated housing and if the need ever arises for protecting a resident alleged to have suffered sexual abuse, that they would place the resident in another wing (unit), ensure their safety and monitor them daily. A memorandum from the Executive Director attesting to this assertion was not provided to this auditor. During the site review and a review of the facility's schematics, this auditor did not observe any areas in the facility that were designated or could be used to segregate a resident alleged to have suffered sexual abuse, for their protection. There was no indicated of such during the review of the resident's files over the last 12 months. *The facility is in compliance with this provision.*

This facility is in compliance with 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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. LLBTHFB Zero Tolerance Policy
c. Email from Executive Director regarding Shreveport Police Department (SPD) conducting criminal investigations for alleged sexual abuse
d. E-mail from Executive Director regarding Louisiana Office of Juvenile Justice (LOJJ) conducting administrative investigation for alleged sexual abuse
e. Resident Files

Interviews included:
a. Administrative Assistant/PREA Coordinator
b. Executive Director
c. Supervisory staff
d. Random Staff

Site Review / Observations:

a. None

115.371 (a) LLBTHFB Zero Tolerance Policy states that "LLBTHFB does not conduct its own criminal or administrative investigations". Criminal investigations are conducted by the Shreveport Police Department (SPD)and administrative investigations are conduct by the Louisiana Office of Juvenile Justice (LOJJ). The Administrative Assistant/PREA Coordinator did provide to this auditor during the pre-audit phase a copy of a memorandum from the Executive Director indicating that LOJJ and SPD regarding their responsibilities for conducting this facility's investigations as applicable. *The facility is in compliance with this provision.*

115.371 (b) LLBTHFB Zero Tolerance Policy states that "LLBTHFB does not conduct its own criminal or administrative investigations. Criminal investigations are conducted by the Shreveport Police Department (SPD) and administrative investigations are conduct by the Louisiana Office of Juvenile Justice (LOJJ). The Administrative Assistant/PREA Coordinator indicated during her interview that LOJJ and SPD personnel, to her understanding, have received training in conducting sexual abuse and sexual harassment investigations involving juvenile victims. *The facility is in compliance with this provision.*

115.371 (c) LLBTHFB Zero Tolerance Policy states that they do not conduct its own criminal or administrative investigations. Criminal investigations are conducted by the Shreveport Police Department (SPD) and administrative investigations are conduct by the Louisiana Office of Juvenile Justice (LOJJ). The Administrative Assistant/PREA Coordinator indicated during her interview that she believes that both the LOJJ and SPD's investigators would gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data, interview all alleged victims, suspected perpetrators and witnesses and would review all prior reports and complaints of sexual abuse involving the suspected perpetrator. *The facility is in compliance with this provision.*

115.371 (d) The Executive Director and the Administrative Assistant/PREA Coordinator stated during their interviews that to their knowledge LOJJ and the SPD would refrain from terminating an investigation solely because the source of the allegation recants the allegation. *The facility is in compliance with this provision.*

115.371 (e) The Executive Director and the Administrative Assistant/PREA Coordinator stated during their interviews that to their knowledge the Shreveport Police Department (SPD) would conduct interviews of all alleged victims, suspected perpetrators and witnesses as an agency practice and refer those cases where the evidence appears to support criminal prosecution to the local and or state prosecutor. LLBTHFB does not conduct any type of investigation and because of this they do not conduct compelled interviews. *The facility is in compliance with this provision.*

115.371 (f) LLBTHFB does not conduct any type of investigation and because of this they do not conduct compelled interviews. The Administrative Assistant/PREA Coordinator stated during her interview that she believes that the Shreveport Police Department (SPD) would assess the credibility of an alleged victim, suspect, witness on an individual basis and not on the basis of the individual's status as a resident or staff and that the resident would not be required to submit to a polygraph examination or other truth telling device as a condition for proceeding. *The facility is in compliance with this provision.*

115.371 (g) LLBTHFB does not conduct any type of investigation. The Administrative Assistant/PREA Coordinator stated during her interview that she believes that the Louisiana Office of Juvenile Justice

(LOJJ), who conducts administrative investigations, to her knowledge, would include an effort to determine whether staff actions or failures to act contributed to the abuse. All administrative investigations are documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind the credibility assessment and the investigative facts and findings. LLBTHFB report zero allegations for sexual abuse in the last 12 months No investigative reports were submitted to this auditor during the pre, onsite and post-audit phases. *The facility is in compliance with this provision.*

115.371 (h) LLBTHFB does not conduct any type of investigation and in the last 12 months there were no criminal investigations conducted by the Shreveport Police Department (SPD). The Administrative Assistant/PREA Coordinator stated during her interview that she believes that all criminal investigations would be documented in written reports that include a description thorough description of the physical evidence and testimonial evidence, the reasoning behind the credibility assessment and the investigative facts and findings. *The facility is in compliance with this provision.*

115.371 (l) The Administrative Assistant/PREA Coordinator stated during her interview that she believes that the Shreveport Police Department (SPD), who conducts all criminal investigations, would refer them for prosecution. LLBTHFB does not conduct any type of investigation and in the last 12 months there were no criminal investigations conducted by the SPD. *The facility is in compliance with this provision.*

115.371 (j) LLBTHFB Zero Tolerance Policy states that they "maintains all written criminal and administrative reports for as long as the alleged abuser is in their program or employed by them, plus at least 5 years". The Administrative Assistant/PREA Coordinator stated during her interview LLBTHFB will maintain all written criminal and administrative reports in accordance to this provision of at least 5 years. *The facility is in compliance with this provision.*

115.371 (k) LLBTHFB Zero Tolerance Policy states that they would encourage the LOJJ or the SPD not to terminate an investigation solely on the basis that the alleged abuser or victim is no longer in their program or employed. This auditor found no evidence of LOJJ and or the SPD doing such during the staff and resident file review while onsite. *The facility is in compliance with this provision.*

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

115.371 (m) LLBTHFB Zero Tolerance Policy states that "would cooperate with the LOJJ and the SPD investigators and will attempt to remain informed about the progress of the investigation".
The Administrative Assistant/PREA Coordinator indicated during her interview that she would fully cooperate with LOJJ and the SPD regarding any investigation being conducted for sexual abuse and harassment and would remain involved until the investigation was completed. *The facility is in compliance with this provision.*

The facility is in compliance with this standard.

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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. LLBTHFB Zero Tolerance Policy
c. Email from the Executive Director regarding the Evidentiary Standard for Investigation
d. Resident Files

Interviews included:

a. Executive Director
b. Administrative Assistant/PREA Coordinator
c. Random Staff

Site Review / Observations:

a. None

115.372 (a) LLBTHFB Zero Tolerance Policy states that "in administrative investigations into allegation of sexual abuse or sexual harassment, the investigator's findings must be based on a preponderance of evidence". The Executive Director and the Administrative Assistant/PREA Coordinator both indicated during their interviews that there were zero administrative investigations conducted by LOJJ in the last 12 months and if one had occurred that all findings would be based on the preponderance of evidence. A memorandum from the Executive Director attesting to this assertion was provided to this auditor. *The facility is in compliance with this provision.*

The facility is in compliance with this standard

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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. LLBTHFB Zero Tolerance Policy
c. Resident Files
d. Employee Files
e. LLBTHFB Notification Letter to Residents

Interviews included:

a. Executive Director
b. Administrative Assistant/PREA Coordinator
c. Random Staff
d. Random Residents

Site Review / Observations:

a. None

115.373 (a) LLBTHFB's Zero Tolerance Policy states that "until a resident is discharged from the facility, LLBTHFB will document all notifications and attempted notifications following an investigation into a resident's allegation of sexual abuse suffered in this facility. This would include whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded".

The Executive Director and the Administrative Assistant/PREA Coordinator both indicated during their interviews that there were no residents who alleged sexual abuse or sexual harassment in the last 12 months, which resulted in an administrative investigation being conducted. A review of the residents file revealed that he was notified of the findings. *The facility is in compliance with this provision.*

115.373 (b) LLBTHFB Zero Tolerance Policy states that "following a resident's allegation that a staff member will request the information from the investigating agency so the resident may be informed." The Executive Director and the Administrative Assistant/PREA Coordinator both stated during their interviews that they would always request information from the Louisiana Office of Juvenile Justice (LOJJ) and from the Shreveport Police Department (SPD) to inform the resident of the investigation's outcome. There were no administrative or criminal investigations conducted in the last 12 months. *The facility is in compliance with this provision.*

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115.373 (c) LLBTHFB Zero Tolerance Policy states that "that following a resident's allegation that a staff member committed sexual abuse against the resident, LLBTHFB informs the resident whenever the following events occur, except when the allegation is determined to be unfounded, or unless the resident has been released from the program, that they will inform the resident whenever:

- The staff member is no longer posted within the residents housing unit
- The staff member is no longer employed at the facility
- LLBTHFB learns that the staff member has been indicted on a charge related to sexual abuse
- Or LLBTHFB learns that the staff member has been convicted on a charge related to the sexual abuse

The Administrative Assistant/PREA Coordinator stated during her interview that there have been no staff on resident sexual abuse allegations in the last 12 months. *The facility is in compliance with this provision.*

115.373 (d) LLBTHFB Zero Tolerance Policy states that "following a resident's allegation that he has been sexually abused by another resident, LLBTHFB informs the alleged victim whenever the following events occur:

- LLBTHFB learns that the alleged abuser has been indicted on a charge related to the sexual abuse; or
- LLBTHFB learns that the alleged abuser has been convicted on a charge related to the sexual abuse.

The Administrative Assistant/PREA Coordinator stated during her interview that there have been no resident-on-resident sexual abuse allegations in the last 12 months that resulted in a resident abuser being indicted or convicted on a charge of sexual abuse. *The facility is in compliance with this provision.*

115.373 (e) The Administrative Assistant/PREA Coordinator stated during her interview that she has and would continue to document and or attempt all notifications to residents regarding the outcome of an administrative or criminal sexual abuse investigation. *The facility is in compliance with this provision.*

The facility is in compliance with this standard.

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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. LLBTHFB Zero Tolerance Policy
c. Resident Files
d. Employee Files
e. Memorandum on Disciplinary Sanctions for Staff

Interviews included:

a. Executive Director
b. Administrative Assistant/PREA Coordinator
c. Human Resources
d. Random Staff

Site Review / Observations:

a. None

115.376 (a) LLBTHFB's Zero Tolerance Policy states that "staff members are subject to disciplinary sanctions up to and including termination of employment for violating LLBTHFB sexual abuse or sexual harassment policies". The Administrative Assistant/PREA Coordinator stated during her interview that there have been no staff disciplinary actions taken against staff in the last 12 months for violating the Zero Tolerance policy. A review of the employee files revealed that no staff in the last 12 months had any disciplinary action taken against them for violating the Zero Tolerance policy. *The facility is in compliance with this provision.*

115.376 (b) LLBTHFB's Zero Tolerance Policy states that "termination of employment is the presumptive disciplinary sanction for staff members who have engaged in sexual abuse". The Administrative Assistant/PREA Coordinator stated during her interview that there have been no staff disciplinary actions, including termination, taken against staff in the last 12 months for violating the Zero Tolerance policy. A review of the employee files revealed that no staff in the last 12 months had any disciplinary action taken against them for violating the Zero Tolerance policy. *The facility is in compliance with this provision.*

115.376 (c) LLBTHFB's Zero Tolerance Policy states that "disciplinary sanctions for violations of LLBTHFB policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) will be 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. The Administrative Assistant/PREA Coordinator stated during her interview that there have been no staff disciplinary actions taken against staff in the last 12 months for violating the Zero Tolerance policy. A review of the employee files revealed that no staff in the last 12 months had any disciplinary action taken against them for violating the Zero Tolerance policy. *The facility is in compliance with this provision.*

115.376 (d) LLBTHFB's Zero Tolerance Policy states that "LLBTHFB reports the following actions to any relevant licensing bodies:

- Terminations of employment for violations of agency sexual abuse or sexual harassment policies; and
- Resignations by staff members who would have been terminated if they had not resigned.

The Administrative Assistant/PREA Coordinator stated during her interview that there have been no staff resignations or disciplinary actions taken against staff in the last 12 months for violating the Zero Tolerance policy. A review of the employee files revealed that no staff in the last 12 months had any disciplinary action taken against them for violating the Zero Tolerance policy. *The facility is in compliance with this provision.*

The facility is in compliance with this standard.

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*)

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

a. PREA Audit Questionnaire (PAQ)
b. LLBTHFB Zero Tolerance Policy
c. Resident Files
d. Employee Files
e. Memorandum for Corrective Action for Contractors and Volunteers

Interviews included:

a. Human Resources
b. Executive Director

c. Administrative Assistant/PREA Coordinator

Site Review / Observations:

a. None

115.377(a) LLBTHFB Zero Tolerance Policy states that "if a contractor or volunteer engages in sexual abuse, LLBTHFB will:

- Prohibit the contractor or volunteer from having any contact with LLBTHFB resident;
- And report the finding of abuse to any relevant licensing bodies.

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The Administrative Assistant/PREA Coordinator stated during her interview that there have been no contractors and or volunteer disciplinary actions taken against any in the last 12 months for violating the Zero Tolerance policy. A review of the contractor and volunteer files revealed that no contractor or volunteer has been employed or provided service to residents in this facility in the last 12 months nor had any disciplinary action taken against them for violating the Zero Tolerance policy. *The facility is in compliance with this provision.*

115.377(b) LLBTHFB's Zero Tolerance Policy states that "if a volunteer or contractor violates LLBTHFB sexual abuse or sexual harassment policies but does not actually engage in sexual abuse, LLBTHFB takes appropriate remedial measures and considers whether to prohibit further contact with LLBTHFB resident". The Administrative Assistant/PREA Coordinator stated during her interview that there have been no contractor and or volunteer disciplinary actions taken against them in the last 12 months for violating the Zero Tolerance policy. A review of the contractor and volunteer files revealed that no contractor or volunteer has been employed or provided service to residents in this facility in the last 12 months nor had any disciplinary action taken against them for violating the Zero Tolerance policy. *The facility is in compliance with this provision.*

The facility is in compliance with this standard

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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. LLBTHFB Zero Tolerance Policy
c. Resident Files
d. Employee Files
e. Memorandum on Interventions and Disciplinary Sanctions for Residents

Interviews included:

a. Executive Director
b. Administrative Assistant/PREA Coordinator
c. Human Resources
d. Intake Staff

Site Review / Observations:

a. None

115.378 (a) LLBTHFB's Zero Tolerance Policy states that states "a resident may be subject to disciplinary sanctions for engaging in sexual abuse only when:

- There is a criminal finding of guilt or an administrative finding that the resident engaged in resident-on-resident sexual abuse; and
- The discipline is determined through a due process hearing.

The Administrative Assistant/PREA Coordinator stated during her interview that no resident has received disciplinary sanctions against them in the last 12 months for engaging in sexual abuse for violating the Zero Tolerance policy. A review of the resident files revealed that no resident in the last 12 months had any disciplinary sanctions against them for engaging in sexual abuse. *The facility is in compliance with this provision.*

115.378 (b) LLBTHFB Zero Tolerance Policy states that "any 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. The Administrative Assistant/PREA Coordinator stated during her interview that there have been no disciplinary sanctions taken against a resident in the last 12 months for engaging in sexual abuse nor was any resident:

- Denied daily large muscle exercise
- Denied legally required educational programming or special education services
- Denied daily visits from a medical or mental health care clinician
- Denied access to other programs and work opportunities

A review of the resident files revealed that no resident in the last 12 months had any disciplinary sanctions against them for engaging in sexual abuse. *The facility is in compliance with this provision.*

115.378 (c) LLBTHFB Zero Tolerance Policy states that "when determining what types of sanctions, if any, should be imposed, that LLBTHFB would consider whether a resident's mental disabilities or mental illness contributed to his behavior". The Administrative Assistant/PREA Coordinator stated during her interview that there have been no disciplinary sanctions taken against a resident in the last 12 months for engaging in sexual abuse and that she would consider whether a resident's mental disabilities or mental illness contributed to his behavior when imposing disciplinary sanctions. *The facility is in compliance with this provision.*

115.378 (d) LLBTHFB's Zero Tolerance Policy states the facility does "offer resident abusers counseling and other interventions designed to address and correct underlying reasons or motivations for the abuse. LLBTHFB 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 the interview with the Administrative Assistant/PREA Coordinator indicated that the offer of therapy, counseling, or other intervention services to an offending resident, as well as to the victim, would be provided and that such participation in these interventions would not be a condition of access to any reward-based behavior management systems or other behavior-based incentives. She further stated that they do refrain from requiring a resident to participate in these services as a condition to access general programming and educational services. A review of the resident files revealed that no resident had been offered therapy, counseling or intervention services in the last 12 months. *The facility is in compliance with this provision.*

115.378 (e) LLBTHFB's Zero Tolerance Policy states "a resident may be disciplined for sexual contact with staff only upon a finding that the staff member did not consent to such contact". During the interview with the Administrative Assistant/PREA Coordinator she stated that no resident had been disciplined in the last 12 months for sexual contact with a staff member that did not consent to such contact. A review of the resident files revealed that no resident had been disciplined in the last 12 months for sexual contact with a staff member that did not consent to such contact. *The facility is in compliance with this provision.*

115.378 (f) LLBTHFB's Zero Tolerance Policy states LLBTHFB "may not discipline a resident if the resident made a report of sexual abuse in good faith based upon a reasonable belief that the alleged conduct occurred not constitute falsely reporting an incident of lying, even if an investigation does not establish evidence sufficient to substantiate the allegation". A review of the resident file revealed that no resident had been disciplined in the last 12 months for making a report of sexual abuse in good faith based upon a reasonable belief that the alleged conduct occurred. *The facility is in compliance with this provision.*

115.378 (g) LLBTHFB's Zero Tolerance Policy states that LLBTHFB "may also discipline a resident for engaging in prohibited sexual activity that does not meet the definition of abuse". During the interview

with the Administrative Assistant/PREA Coordinator she stated that no resident had been disciplined for engaging in prohibited sexual activity that does not meet the definition of sexual abuse. A review of the resident file revealed that no resident had been disciplined in the last 12 months for engaging in prohibited sexual activity that does not meet the definition of abuse. *The facility is in compliance with this provision.*

This facility is in compliance with this standard.

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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. LLBTHFB Zero Tolerance Policy
c. Resident Files
d. Employee Files
e. Written Institutional Coordination Response Plan
f. Executive Director Memorandum for Medical and Mental Health Screenings; History of Sexual Abuse
g. Objective Risk Assessment Instrument

Interviews included:

a. Executive Director
b. Administrative Assistant/PREA Coordinator
c. Human Resources
d. Intake Staff
e. Random Staff

Site Review / Observations:

a. None

115.381 (a) LLBTHFB Zero Tolerance Policy states that "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, that staff would ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening". The intake staff indicated that they currently do not have an objective screening tool to make these types of assessments in accordance with 115.341. During the interview with the Intake staff, she stated during her interview that there had been no residents in the last 12 months who indicated a prior sexual victimization in an institutional or community setting during the intake screening. A review of the resident files revealed that no resident indicated during the intake screening that they had experience any prior sexual victimization, whether it occurred in an institutional setting or in the community, was offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. *The facility is not in compliance with this provision.*

115.381 (b) LLBTHFB Zero Tolerance Policy states that "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, that staff would ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening". During the interview with

the Intake staff, she stated during her interview that there had been no residents in the last 12 months who had previously perpetrated a sexual abuse in an institutional or community setting, as documented during the intake screening, required a referral to medical or mental health practitioner. A review of the resident files revealed that no resident had perpetrated a sexual abuse, whether it occurred in an institutional setting or in the community, was offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. *The facility is in compliance with this provision.*

115.381 (c) The Administrative Assistant/PREA Coordinator, Administrative Assistant/PREA Coordinator and the Intake staff all indicated during their interviews that any related sexual victimization or abusiveness that may occur in an institutional setting is strictly limited to mental health practitioners and the administrative management staff as necessary to inform them of treatment plans, security management decisions including housing, bed, work, education, and program assignments, or as otherwise required by federal, state, or local law. A review of the resident files revealed that no resident had any related sexual victimizations or abusiveness that occurred in an institutional setting or in the community, requiring a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. During the interviews with the random staff, they all indicated that they are only informed about a resident's treatment plans and security management decisions as it pertains to housing, bed, work, education and program assignments. *The facility is in compliance with this provision.*

115.381 (d) LLBTHFB's Zero Tolerance Policy states that "medical and mental health practitioners must obtain informed consent from resident before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18". A review of the resident's files revealed that some of the residents in LLBTHFB are under the age of 18 and therefore a mandated by law to report any prior sexual abuse that did not occur in an institutional setting. The Administrative Assistant/PREA Coordinator, Administrative Assistant/PREA Coordinator and the Intake staff both indicated during their interviews that they are mandated to report sexual abuse of a resident whether it occurred in an institutional setting or in the community. *The facility is in compliance with this provision.*

This facility is not in compliance with this standard.

Corrective Action Findings: The facility needs to develop, implement and institutionalize the objective screening instrument in accordance to 115.341 in order to make the appropriate assessments and referrals as per this provision in order to be in compliance with this standard.

Corrective Action Response: The PREA Coordinator did provide for this auditor's review the created objective screening instrument in accordance to 115.341 in order to make the appropriate assessments and referrals as per this provision. She also provided copies of this instrument of all new intakes and reassessments during this post-audit phase in order to demonstrate institutionalization of this practice. The facility is in compliance with this standard.

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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. LLBTHFB Zero Tolerance Policy
c. Resident Files
d. Executive Director Memorandum on Access to Emergency Medical and Mental Health services
e. Executive Director Memorandum of Understanding with Project Celebration

Interviews included:

a. Executive Director

b. Administrative Assistant/PREA Coordinator
c. Intake Staff
d. Random Staff

Site Review / Observations:

a. None

115.382 (a) LLBTHFB Zero Tolerance Policy states that "resident victims of sexual abuse will 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 judgement". The Administrative Assistant/PREA Coordinator and the Administrative Assistant/PREA Coordinator stated during their interviews that a resident victim will receive and be provided 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 judgement. A review of the Memorandum of Understanding from Project Celebration substantiated their assertion. *The facility is in compliance with this provision.*

115.382 (b) LLBTHFB Zero Tolerance Policy, (pg. 15) states that "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 and must immediately notify the appropriate medical and mental health practitioner". The Administrative Assistant/PREA Coordinator indicated during her interview that all staff have been trained as first responders who will immediately take steps to protect the victim, contact the Administrative Assistant/PREA Coordinator, the Executive Director and the Shreveport Police Department (SPD), who would take the victim to the Willis Knight hospital for medical and mental health care through the Project Celebration's consortium services. During the interviews with the random staff and first responders, they all indicated that when they become aware that of a sexual abuse allegation, they would separate a victim from the perpetrator, preserve the evidence if applicable, contact their supervisor, call the hotline number, call law enforcement and keep the resident near them until their supervisor and law enforcement arrives. LLBTHFB reported no allegation of sexual abuse or sexual harassment in the last 12 months. A review of the employee and resident records corroborates this assertion. *The facility is in compliance with this provision.*

115.382(c) LLBTHFB's Zero Tolerance Policy states that "resident are provided timely information about and timely access to emergency contraception and sexually transmitted infection prophylaxis in accordance with professionally accepted standards of care, where medically appropriate". During the interview with the Administrative Assistant/PREA Coordinator, she stated that the Willis Knight and or LSU Oschner Hospital provision of services through the Project Celebration would provide timely information about and timely access to emergency contraception and sexually transmitted infection prophylaxis to the resident victim.

A review of the Memorandum of Understanding with the Project Celebration provision of services through the Willis Knight and or LSU Oschner hospitals substantiated her assertion. This is an all-male facility. *The facility is in compliance with this provision.*

115.382 (d) LLBTHFB's Zero Tolerance Policy, (pg. 15) states "LLBTHFB 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 Willis Knight hospital's SANE Nurse also indicated during her interview that forensic medical services are provided at no cost to a resident victim. A review of the Memorandum of Understanding with Project Celebration's consortium services supports the

SANE nurse's assertion. The Administrative Assistant/PREA Coordinator also stated during her interview that the above services are provided at no cost to a resident victim. *The facility is in compliance with this provision.*

This facility is in compliance with this standard.

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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. LLBTHFB Zero Tolerance Policy
c. Resident Files
d. Executive Director Memorandum for Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers

Interviews included:

a. Executive Director
b. Administrative Assistant/PREA Coordinator
c. Intake Staff
d. Random Staff
e. The Project Celebration's Hotline representative

Site Review / Observations:

b. None

115.383(a) LLBTHFB's Zero Tolerance Policy states that "LLBTHFB offers medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in

any prison, jail, lockup, or juvenile facility". The Administrative Assistant/PREA Coordinator indicated during her interview that appropriate medical and mental health evaluations and treatment will be provided to all residents who have been victimized by sexual abuse in a juvenile facility. *The facility is in compliance with this provision.*

115.383(b) LLBTHFB Zero Tolerance Policy states that "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 Administrative Assistant/PREA Coordinator indicated during her interview that residents, as appropriate, would receive follow-up services, treatment plans, and, when necessary, and referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. A review of the resident files indicated that no resident needed follow up services due to a sexual abuse when released from the facility. *The facility is in compliance with this provision.*

115.383(c) LLBTHFB's Zero Tolerance Policy states that states that "LLBTHFB provides such victims with medical and mental health services consistent with the community level of care". The Administrative Assistant/PREA Coordinator that the medical and mental health services that a resident sexual abuse victim would receive is consistent with the community level of care since they would be provided at the Willis Knight and or LSU Oschner Hospital's provision of services through Project Celebration. *The facility is in compliance with this provision.*

115.383 (d) LLBTHFB is an all-male facility, however in the event of the presence of a transgender male, the Administrative Assistant/PREA Coordinator indicated during her interview that a pregnancy test would be appropriate following any sexually abusive vaginal penetration. The SANE nurse at the Willis Knight Hospital confirmed that they would offering pregnancy test, providing timely and comprehensive information about and to all lawful pregnancy related medical services, and testing for sexually transmitted infections to a sexual abuse victim resident as part of their protocol. *The facility is in compliance with this provision.*

115.383 (e) LLBTHFB is an all-male facility, however in the event of the presence of a transgender male with female genitals, the Administrative Assistant/PREA Coordinator indicated during her interview that a resident would receive timely and comprehensive information about and timely access to all lawful pregnancy related medical services following any sexually abusive vaginal penetration. The SANE nurse at Willis Knight hospital confirmed that they would offering pregnancy test, providing timely and comprehensive information about and to all lawful pregnancy related medical services, and testing for sexually transmitted infections to a sexual abuse victim resident as part of their protocol. *The facility is in compliance with this provision.*

115.383 (f) LLBTHFB Zero Tolerance Policy states that "LLBTHFB will ensure that tests for sexually transmitted infections are offered, as medically appropriate, to resident victims of sexual abuse while in their facility". The SANE nurse at Willis Knight Hospital confirmed that they would ensure that tests for sexually transmitted infections are offered, as medically appropriate, to resident victims of sexual abuse. A review of the resident files revealed that no resident had been referred to the Willis Knight and or LSU Oschner Hospitals for tests for sexually transmitted infections as a sexual abuse victim. *The facility is in compliance with this provision.*

115.383 (g) According to LLBTHFB's Zero Tolerance Policy states that "LLBTHFB 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." the Administrative Assistant/PREA Coordinator indicated during her interview that all services received by a resident referred to the Willis

Knight and or LSU Oschner Hospitals would be at no cost to the resident. A review of the resident files revealed that no resident had been referred to the Willis Knight and or LSU Oschner Hospitals for any of their services in the last 12 months. There were no residents in the population to interview who had been referred to the Willis Knight and or LSU Oschner Hospitals in the last 12 months. *The facility is in compliance with this provision.*

115.383(h) LLBTHFB Zero Tolerance Policy states that "LLBTHFB 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". These services would be sought through Project Celebration. The Administrative Assistant/PREA Coordinator did indicate during her interview that once they learn or become aware of a known resident on resident abuser's abuse history, that within 60 days they would refer the resident to mental health practitioners. She also stated that they would seek a mental health evaluation and the offer treatment, upon learning of such abuse history, through Project Celebration. *This facility is in compliance with this provision.*

The facility is in compliance with this standard.

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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. LLBTHFB Zero Tolerance Policy
c. Resident Files
d. Executive Director Memorandums on Sexual Incident Reviews for 2021

Interviews included:

a. Executive Director
b. Administrative Assistant/PREA Coordinator
c. Sexual Abuse Incident Review Team member

Observations included:

a. None

115.386 (a) LLBTHFB's Zero Tolerance Policy states that "LLBTHFB 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 Administrative Assistant/PREA Coordinator stated during her interview that a sexual abuse incident review would be conducted at the conclusion of every sexual abuse investigation, including for allegations that are Unsubstantiated, unless the allegation has been determined to be Unfounded. LLBTHFB report zero allegations for sexual abuse that were investigated administratively or criminally. Administrative Assistant/PREA Coordinator did not provide a memorandum from the Executive Director for the last 12 months indicating that zero sexual abuse incident reviews had occurred. A review of the resident, employee and investigative records revealed that there were zero Unsubstantiated and Substantiated allegation of sexual abuse that occurred in the last 12 months. *The facility is not in compliance with this provision.*

115.386 (b) LLBTHFB Zero Tolerance Policy states that LLBTHFB conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, within 30 days, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded. The Administrative Assistant/PREA Coordinator indicated that there were zero sexual abuse incident reviews in the last 12 months. A review of the resident, employee and investigative records revealed that there were zero Unsubstantiated and Substantiated allegations of sexual abuse that occurred in the last 12 months. *The facility is in compliance with this provision.*

115.386 (c) The LLBTHFB incident review team includes upper-level management officials, with input from line supervisors, investigators, and outside medical or mental health practitioners. The LLBTHFB team consists of the following individuals:

a. Executive Director
b. Administrative Assistant/PREA Coordinator

During the interviews with the Administrative Assistant/PREA Coordinator she stated that once a meeting would convene, that input would be provided by them regarding how to prevent further incidents of sexual abuse and sexual harassment from occurring. A review of the resident, employee and investigative records revealed that there were zero Unsubstantiated and Substantiated allegation of sexual abuse that occurred in the last 12 months. Since the incident review team had not been identified nor formed during the pre and onsite audit phase, no team member could be interviewed. *The facility is not in compliance with this provision.*

115.386(d) LLBTHFB Zero Tolerance Policy states that LLBTHFB would:

- 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 Administrative Assistant/PREA Coordinator.

The Administrative Assistant/PREA Coordinator did not provide memorandums or other proof documentation for the last 12 months reflecting that no sexual abuse incident review occurred due to no sexual abuse investigative findings being Unsubstantiated or Substantiated. *The facility is not in compliance with this provision.*

115.386 (e) LLBTHFB Zero Tolerance Policy states that "LLBTHFB would submit a report of its findings to the Executive Director and other appropriate staff to implement the recommendations for improvement, or document its reasons for not doing so". The Administrative Assistant/PREA Coordinator did not provide any reports or other proof documentation for the last 12 months indicating that zero sexual abuse incident reviews occurred. Due to no sexual abuse investigative findings being Unsubstantiated or Substantiated, there were no recommendations for any improvements required. *The facility is in compliance with this provision.*

This facility is not in compliance with this standard.

Corrective Action Findings: The facility must identify and provide a title listing of the incident review team members and provide proof documentation in the form of a memorandum indicating that there were no sexual abuse reviews for the last 12 months. For the next 3 months, the facility must provide to this auditor memorandums informing the incident review team member that no meeting will occur due to zero sexual abuse or sexual harassment investigations or provide the meeting minutes of the same, in order to be in compliance with this standard.

Corrective Action Response: The PREA Coordinator did provide a title listing of the incident review team members and did provide proof documentation in the form of a memorandum from the Executive Director indicating that there were no sexual abuse reviews for the last 12 months. The facility did provide to this auditor a memorandum over a 3-month period informing the incident review team members that no sexual abuse review meeting had occurred due to zero sexual abuse or sexual harassment investigations. The facility is in compliance with this standard.

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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. LLBTHFB Zero Tolerance Policy
c. Memorandum Regarding Data Collection

Interviews included:

a. Executive Director
b. Administrative Assistant/PREA Coordinator

Observations included:

a. Agency website: www.info@northwestlouisianacdc.org

115.387(a) LLBTHFB's Zero Tolerance Policy states that "LLBTHFB collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. The Administrative Assistant/PREA Coordinator indicated during her interview that they do not collect accurate data on every allegation from other facilities not under their control using a standardized instrument and set of definitions. They currently have only the one facility and there have been zero sexual abuse or sexual harassment allegations in the last 12 months. She further stated that she will place the 2019 and 2020 data on a spreadsheet for future reporting purposes. *The facility is not in compliance with this provision.*

115.387 (b) LLBTHFB Zero Tolerance Policy states that "LLBTHFB collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions and aggregates the data at least once each year". During the interviews with the Administrative Assistant/PREA Coordinator and the Executive Director it was ascertained that they had not aggregated this incident annually that occurred in calendar year of 2020 nor for the last 3 years. They only have the one facility and there have been no sexual abuse and sexual harassment allegations in the last 36 months, specifically in the last 12 months to report. *This facility is not in compliance with this provision.*

115.387 (c) The Administrative Assistant/PREA Coordinator and the Executive Director both indicated during their interviews that they do not participate in the Survey of Sexual Violence conducted by the Department of Justice (DOJ) but if they did, their incident-based data would include the data necessary to answer the questions on the said survey. *The facility is in compliance with this provision.*

115.387 (d) The Administrative Assistant/PREA Coordinator and the Executive Director both indicated during their interviews that they would maintain, review, and collect data as needed from available incident-based documents, including reports, investigation files and sexual abuse incident reviews. They further indicated that no data has been collected thus far, though there has been no sexual abuse and sexual harassment allegations, but did provide a memorandum reflecting that there were zero allegations of sexual abuse and sexual harassment have occurred in the facility over the last 36 months and specifically, in the last 12 months. *The facility is not in compliance with this provision.*

115.387 (e) The Administrative Assistant/PREA Coordinator and the Executive Director both indicated during their interviews that they do not contract for the confinement of their residents with another private facility. *The facility is in compliance with this provision.*

115.387 (f) The Administrative Assistant/PREA Coordinator and the Executive Director both indicated during their interviews that they would provide, upon request, all such data from the previous calendar year to the Department of Justice no later than June 30. They further stated that DOJ has not requested agency data in the last 3 years as well as in the 12 months. *The facility is in compliance with this provision.*

This facility is not in compliance with this standard.

Corrective Action Findings: LLBTHFB must collect and aggregate all sexual abuse data for 2020, at least once a year, create an annual report and provide a copy to this auditor for his review. These annual reports must be posted on the agency's website or in a location where the public can access and review them as well as this auditor, in order to be in compliance with this standard.

Corrective Action Response: The PREA Coordinator did provide a memorandum from the Executive Director for this auditor's review indicating that they will collect and aggregate all sexual abuse data for 2020, will create an annual report thereafter and will post these reports on the agency's website or in the facility's lobby display case for the public's view and access. She also provided pictures of the facility's lobby display case demonstrating that this report is posted and is available for the public's view and access. The facility is in compliance with this standard.

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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. LLBTHFB Zero Tolerance Policy
c. Executive Director Memorandum regarding Data Correction

Interviews included:

a. Executive Director
b. Administrative Assistant/PREA Coordinator

Site Review / Observations:

a. Agency webpage: www.info@northwestlouisianacdc.org

115.388 (a) The Administrative Assistant/PREA Coordinator stated during her interview that she has not but would review any and all 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
- Taking corrective action on an ongoing basis.

She stated that she has not collected nor prepared an annual report for 2019 or for 2020 of her findings nor has she recommended to the Executive Director any corrected actions for the facility. She further stated that the during the previous 3 years there were no sexual abuse and sexual harassment allegations. *The facility is not in compliance with this provision.*

115.388 (b) The Administrative Assistant/PREA Coordinator stated during her interview although she did not complete an annual report for 2019 or 2020 but, once she does, the comparison of the current year's data and corrective actions, which were zero, with those from prior years would provide an assessment of the agency's progress in addressing sexual abuse. *The facility is not in compliance with this provision as indicated per 115.388 (a).*

115.388 (c) The Administrative Assistant/PREA Coordinator stated during her interview that although she did not complete an annual report for 2019 or 2020 but, once she does, the annual report would be

approved by the Executive Director and made readily available to the public though the agency's website once created. *The facility is not in compliance with this provision as indicated per 115.388 (a).*

115.388 (d) The Administrative Assistant/PREA Coordinator stated that during her interview that although she did not complete an annual report for 2019 or 2020 but, once she does, the annual report would indicate the nature of the material redacted and where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of the facility. *The facility is not in compliance with this provision as indicated per 115.388 (a).*

This facility is not in compliance with this standard.

Corrective Action Findings: LLBTHFB must create and develop an annual PREA report, have the Executive Director approve, sign, then post it on the agency website, as well as provide to this auditor a copy of the 2019 and 2020 Annual Report that compares aggregated incident data reflecting zero sexual abuse and zero sexual harassment allegations of the past 12 months (2020). This report must also be compared to the previous year's data of 2019, including any recommended corrective actions and or improvements to be implemented, in order to be in compliance with this standard.

Corrective Action Response: The PREA Coordinator did create and develop an annual PREA report for 2020 that compares aggregated incident data reflecting zero sexual abuse and zero sexual harassment allegations of the past 36 months and more specifically, the last 12 months. This report did not include any recommended corrective action or improvements since they have been sexual; abuse and sexual harassment allegation/incident free for the past 36 months. The Executive Director approved and sign this report as required and all personal identifiers have been redated from this report. The facility is in compliance with this standard.

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*)

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

Documents reviewed included:

a. PREA Audit Questionnaire (PAQ)
b. LL Brandon III RTC Zero Tolerance Policy
c. LLBTHFB Annual Report for 2020

Interviews included:

a. Executive Director
b. Administrative Assistant/PREA Coordinator

Site Review / Observations:

Agency web page: www.info@northwestlouisianacdc.org

115.389 (a) LLBTHFB's Zero Tolerance Policy states that the "LLBTHFB will collect and retain sexual abuse and sexual harassment data in a secure manner". The Administrative Assistant/PREA Coordinator indicated during her interview that all sexual abuse and sexual harassment data collected will be securely retained pursuant to 115.387. She further stated that this information is securely retained in the Executive Director's office under lock and key and by password in the computer of which only administrative staff have access to it. The Executive Director corroborated this assertion during his interview. *The facility is in compliance with this provision.*

115.389 (b) The Administrative Assistant/PREA Coordinator indicated during her interview that all aggregated sexual abuse data, from facilities under its direct control, though they do not contract for the confinement of their residents to another private facility, would be readily available to the public at least annually through the agency's website or some other medium once the 2019 and 2020 annual reports are completed and approved by the Executive Director. She further indicated that this has not occurred as of the onsite audit phase. *This facility is not in compliance with this provision.*

115.389 (c) The Administrative Assistant/PREA Coordinator stated during her interview that although she did not complete an annual report for 2019 nor for 2020 but, once she does, she would remove all

personal identifiers before making the aggregated sexual abuse data available to the public though the agency's website. *The facility is not in compliance with this provision as indicated per 115.388 (a).*

115.389 (d) The Administrative Assistant/PREA Coordinator and the Executive Director stated during their interviews LLBTHFB would maintain all sexual abuse data collect pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise*. This facility is in compliance with this standard.*

This facility is not in compliance with this standard.

Corrective Action Findings: LLBTHFB must create and develop an annual PREA report, remove all personal identifiers before making it available to the public, have the Executive Director approve, sign, then post it on the agency website, as well as provide to this auditor with a copy. The Annual Report must compare the aggregated incident data that reflects zero sexual abuse and zero sexual harassment allegations of the past 12 months (2020). This report must also be compared to the previous year's data of 2019, including any recommended corrective actions and or improvements to be implemented, in order to be in compliance with this standard.

Corrective Action Response: The PREA Coordinator did create and develop an annual PREA report for 2020 that compares aggregated incident data reflecting zero sexual abuse and zero sexual harassment allegations of the past 36 months and more specifically, the last 12 months. This report did not include any recommended corrective action or improvements since they have been sexual; abuse and sexual harassment allegation/incident free for the past 36 months. The Executive Director approve and sign this report as required and all personal identifiers have been redated from this report. The facility is in compliance with this standard.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

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

115.401 (a)

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

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard*.) ☒ Yes ☐ No

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

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

115.401 (h)

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

115.401 (i)

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

115.401 (m)

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

115.401 (n)

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

Auditor Overall Compliance Determination

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

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

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

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

Documents reviewed included:

a. N/A

Interviews included:

a. Executive Director
b. Administrative Assistant/PREA Coordinator

Site Review / Observations:

a. Agency web page: www.info@northwestlouisianacdc.org
b. Site Review (Tour)

115.401(a) The Executive Director and the Administrative Assistant/PREA Coordinator both stated during their interviews that LLBTHFB has never been audited. *The facility is in compliance with this provision.*

115.401 (b) The Executive Director and the Administrative Assistant/PREA Coordinator both stated during their interviews that this is the first year of the current audit cycle. *The facility is in compliance with this provision.*

115.401 (h) During the onsite phase of this audit this auditor did have access to, and the ability to observe, all areas of LLBTHFB's administrative building, housing areas, interior, exterior, etc. of this facility *The facility is in compliance with this provision.*

115.401 (I) During the onsite phase of this audit this auditor was permitted to request and receive copies of any relevant document including electronically stored information from LLBTHFB's administrative files and records. *The facility is in compliance with this provision.*

115.401 m. During the onsite phase of this audit this auditor was able to conduct interviews with the residents and staff members in a private setting (e.g., in an office with a door) away from the earshot of staff and residents. *The facility is in compliance with this provision.*

115.401 n. During the pre-audit, onsite and post-audit phase of this audit, residents were and are permitted to send confidential information or correspondence to this auditor in the same manner as if they were communicating with legal counsel. As of the writing of this report, this auditor has not received any confidential information or correspondence from a resident and or staff from LLBTHFB to date. *The facility is in compliance with this provision.*

This facility is in compliance with this standard.

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*)

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

Documents reviewed included:

a. None

Interviews included:

a. Executive Director
b. Administrative Assistant/PREA Coordinator

Site Review / Observations:

a. Agency web page: www.info@northwestlouisianacdc.org

115.403 (f) A review of LLBTHFB's website as well as interviews with the Executive Director and the Administrative Assistant/PREA Coordinator revealed that this facility has never been PREA audited. There was no proof documentation to be found in the facility's records to state otherwise upon review during the site review. *The facility is in compliance with this provision.*

This facility is in compliance with this standard.

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.

Jerome K. Williams April 4th, 2022

Auditor Signature **Date**