PREA Facility Audit Report: Final

Name of Facility: Minnie Rogers Juvenile Justice Center
Facility Type: Juvenile
Date Interim Report Submitted: NA
Date Final Report Submitted: 09/06/2019

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.	☑
I have not included in the final report any personally identifiable information (PII) about any inmate/resident/detainee or staff member, except where the names of administrative personnel are specifically requested in the report template.	☐
Auditor Full Name as Signed: Derek Craig Henderson	**Date of Signature:** 09/06/2019

AUDITOR INFORMATION	
Auditor name:	Henderson, Derek
Address:	
Email:	derek.henderson@mctx.org
Telephone number:	
Start Date of On-Site Audit:	07/24/2019
End Date of On-Site Audit:	07/26/2019

FACILITY INFORMATION	
Facility name:	Minnie Rogers Juvenile Justice Center
Facility physical address:	5326 Hwy 69 South, Beaumont, Texas - 77705
Facility Phone	4097227474
Facility mailing address:	

Primary Contact	
Name:	Dennis Copeland
Email Address:	dcopeland@co.jefferson.tx.us
Telephone Number:	4097262811

Superintendent/Director/Administrator	
Name:	Dennis Copeland
Email Address:	dcopeland@co.jefferson.tx.us
Telephone Number:	4097262811

Facility PREA Compliance Manager	
Name:	
Email Address:	
Telephone Number:	

Facility Health Service Administrator On-Site	
Name:	DR. Cecil Walkes
Email Address:	jroberts@co.jefferson.tx.us
Telephone Number:	4098358530

Facility Characteristics	
Designed facility capacity:	48
Current population of facility:	22
Average daily population for the past 12 months:	
Has the facility been over capacity at any point in the past 12 months?	No
Which population(s) does the facility hold?	
Age range of population:	10-17
Facility security levels/resident custody levels:	
Number of staff currently employed at the facility who may have contact with residents:	52
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	
Number of volunteers who have contact with residents, currently authorized to enter the facility:	

AGENCY INFORMATION	
Name of agency:	Minnie Rogers Juvenile Justice Center
Governing authority or parent agency (if applicable):	
Physical Address:	5326 Hwy 69 South, Beaumont, Texas - 77705
Mailing Address:	
Telephone number:	

Agency Chief Executive Officer Information:	
Name:	
Email Address:	
Telephone Number:	

Agency-Wide PREA Coordinator Information			
Name:	Dennis Copeland	**Email Address:**	dcopeland@co.jefferson.tx.us

AUDIT FINDINGS

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

NARRATIVE

The Jefferson County Juvenile Probation Department (JCJPD) requested a PREA Audit for the Minnie Rogers Juvenile Justice Center (MRJJC) located in Beaumont, Texas. The MRJJC is located at 5326 Hwy 69 South, Beaumont, Texas 77705; and the Center was opened on June 24th, 2002. The Center is a pre-adjudication 48 bed secure facility housing male and female juvenile offenders between the ages of 10 – 18, and the MRJJC had an average daily population of 17 residents in 2018. The audit was conducted by one Department of Justice certified PREA Auditor, Derek Henderson, whom will be mentioned throughout this report as the 'Auditor." Additionally, the "Facility" referred to throughout this report shall be the Minnie Rogers Juvenile Justice Center (MRJJC), and the "Agency" shall be the parent agency over the MRJJC, the "Jefferson County Juvenile Probation Department (JCJPD)." The MRJJC last PREA audit was conducted by Joel Whitt M.A. from San Antonio in 2016, and the Agency has posted this report on their website. The Final PREA Audit Report issued on 10/06/2016 reflects that the MRJJC was found to be in full compliance with all 41 PREA Juvenile Standards and exceeded the PREA requirements of two of the 41 standards (§115.317 and §115.318). The agreement for this PREA Audit between the Agency and the Auditor was initiated as the Auditor working pro bono through his current employer; therefore, a contract for auditing services was not created. The Auditor did not experience any obstacles or barriers throughout the audit process to note at this time, and the Agency was quick to respond to any follow-up or issues the Auditor brought to their attention.

Pre-Onsite Audit Phase

The pre-onsite audit phase began on 3/28/19, with the PREA Resource Center (PRC) providing the Auditor, Derek Henderson, and the Agency (JCJPD) access to the Online Audit System (OAS). The OAS was the agreed upon method of completing the Pre-Audit Questionnaire (PAQ) by the Agency and the Auditor due to the security and accessibility the Online System offers.

An initial meeting was arranged by phone with the Facility Administrators on 4/23/19, and during this call the Auditor talked with the PREA Coordinator/Detention Superintendent and Casework Manager. The Auditor explained the entire auditing process, including: the three phases (pre-onsite, onsite, and post onsite), the OAS and PAQ, the interim and final report, and corrective action (if required). Additionally, the Agency Administrators provided the Auditor with answers to facility specific questions, and the primary point of contact was set as the PREA Coordinator/Detention Superintendent with the Agency. The PREA Resource Center (PRC) website was discussed, and the Auditor described how to access the PRC website to download the paper version of the PAQ, instructions for the PREA audit tour, interview question protocols, process map, and a checklist for documents that will be needed. The Auditor also explained that the PREA Audit is not only a document review of applicable policies, documents, and forms; but also a comprehensive review and analysis of how the PREA Standards are practiced in the

facility and how the Auditor must have unimpeded access to all areas of the facility when onsite. The Auditor discussed the planning and logistics of the onsite, instructions and timelines for posting of the Auditor Notice, how the PAQ requires all the Agency's related policies and supporting documents uploaded in the OAS, the contacts that will be made prior to the onsite (advocate groups, SANE/SAFE, and other non-agency affiliates), and how many staff and residents will be interviewed and where the interviews will be conducted. The Auditor provided the Administrators with timelines of when the PAQ should be completed (by 6/14/19), when the interim and/or final report is due, and, if applicable, the deadline for full implementation of any corrective action that is deemed to be required. The PREA Resource Center (PRC) and the helpful information, documents, and links that are on the site was described by the Auditor, and the Auditor provided the Agency Administrators the times the Auditor will be available for any follow-up calls and/or communications. The Auditor also discussed how an Issue Log will be developed for any questions or follow-up information needed while the Auditor reviews the PAQ in the OAS. It was explained that if applicable, an Issue Log will be sent to the PC weekly, with a Facility response for each weekly Issue Log being due within 5 business days (or longer if needed). Additionally, the Auditor explained that if the Agency would need more time to respond to an Issue Log, that the PC would just need to communicate this with the Auditor and more time can be arranged.

After the initial conference call, on 4/24/19, the Auditor sent the PREA Coordinator (PC) the Auditor Notice form, with instructions on where, when, and for how long to post. The Auditor explained that it is strongly recommended that the Auditor Notice be posted in areas throughout the facility that are visible to all residents and staff (i.e., visiting areas, housing units, and recreational spaces). The PC provided the Auditor with proof of the postings on 4/29/19 (pictures of each of the posting locations), and the Agency also posted the notice on their website. The notices were posted in Spanish and English, on bright light blue and pink paper, and they were posted in 41 locations throughout the inside and outside of the facility. It should be noted that the Agency posted the Auditor Notice approximately 12 weeks prior to the onsite audit and throughout all areas in the facility, the visitation waiting area outside the facility, and on their website; therefore, substantially exceeding the PREA Auditor Handbooks strong recommendation of posting the notice within at least 6 weeks prior to the onsite. The Auditor Notice provided a private and confidential method for staff, residents, and the public to contact the Auditor via a P.O. Box mailing address. Agency leadership explained to the auditor that residents are able to send mail to the auditor's P.O. Box through their internal mail process, and at no time did the auditor receive such a correspondence.

During the pre-onsite phase, from when the PAQ was completed by the Agency in the OAS on 6/10/19 to the date of the onsite (7/24/19), the Auditor analyzed and reviewed all the answers in the PAQ and all the secondary documentation uploaded by the Agency in the OAS. As noted above, each issue that arose or clarification needed due to a lack of information in the PAQ, the Auditor documented the issue in an Issue Log. An example of the documents supplied by the Agency in the OAS system that were reviewed by the Auditor are as follows:

- Policies
- Procedures
- Logs
- PREA Training Verification Forms
- PREA Acknowledgement Forms
- Statistics
- Reports
- Memorandums of Understanding (MOUs)

- Advocate Information
- Investigative Information
- Department Forms
- Organizational Chart and Facility Schematics
- Staff Plan and Aggregate Data Documents
- Criminal History and Child Abuse Registry Information
- Training Certificates
- Detention Handbook
- Survey of Sexual Victimization, 2017 (from the Department of Justice)

A second conference call was conducted on 7/8/19 to follow-up on the status of the audit and discuss the onsite phase that was scheduled for 7/24/19 – 7/26/19. The Auditor and the Agency's PREA Coordinator (PC) and Casework Manager (CW) were included on the call, and the Auditor provided a detailed schedule for each day of the onsite. The Auditor also sent a specialized staff roster that included spaces for the Agency to document the specialized staff that he was going to interview, the hours they generally work, their official titles, and their contact numbers. The call also covered the area the Auditor will be working from when onsite and where the interviews would be conducted. The schedule for the first day of the onsite was discussed, and the Auditor explained that it would begin with an initial meet and greet, then a facility inspection, and the rest of the day would be spent on interviewing residents. The Auditor discussed how he will need to interview targeted and random residents that are available during the onsite, observe an intake (specifically related to PREA orientation and risk screening processes), and randomly selected staff from each shift. It should be noted that at no time during the auditor's onsite visit was a resident admitted into the facility; therefore, no such observation of an intake was conducted by the auditor. Targeted residents were described to the PC and CW as: residents with disabilities or limited English proficient (LEP); residents who identify as lesbian, gay, bisexual, transgender, or intersex (LGBTI); residents in segregated housing or isolation; residents who reported sexual abuse; and residents who reported sexual victimization or abusiveness during risk screening. The full list of specialized staff that would need to be interviewed while onsite was discussed, and included: agency contracts administrator, intermediate or higher level staff who conduct unannounced rounds, educational staff, medical and mental health staff, human resource staff (HR), SANE/SAFE nurse (via phone call), volunteers and contractors who may have contact with residents, staff who perform risk screenings (Juvenile Supervision Officers {JSOs} who work intake), staff who supervise residents in isolation (JSOs), staff on the sexual abuse incident review team, designated staff member in charge of retaliation, first responders (JSOs), and intake staff (JSOs who work intake).

The schedule for the second day was discussed, and the Auditor talked about how he would finish up the resident interviews on this day (if applicable); continue or start with staff interviews; review employee personnel and training files, investigative files, and resident files; and conduct specialized staff interviews. Day three was explained by the Auditor as involving the continuation of what was not completed on day two, the discussion of any unresolved issue log items and/or non-compliance issues exposed while onsite, and the exit interview. Furthermore, during this call the Auditor explained the overall purpose of corrective action (if applicable), that corrective action should be generally expected due to the over 300 PREA provisions included in the 41 juveniles standards, and that corrective action should not be looked at negatively; instead it should be viewed as an opportunity to enhance best practices and ensure safety and security for all persons involved with the Jefferson County Juvenile Probation Department. The Auditor explained that he will send the PC a document that will include the talked about daily schedule of the onsite and a list of items the Auditor will need the first day of the onsite- to include: detention resident rosters for the days of the onsite, staff rosters for the days of the onsite, and staff schedules for the

month of July. Additionally, the Auditor explained that he will need grievance logs, incident reports, all allegations of sexual abuse and sexual harassment reported for investigation, and all hotline calls for the past 12 months. The Auditor also informed the PC and CW that he will need a detailed list of the number of sexual abuse and sexual harassment allegations in the past 12 months, including the following information:

- Total number of allegations.
- Number determined to be Substantiated, Unsubstantiated, or Unfounded.
- Number of cases in progress.
- Number of criminal cases investigated.
- Number of administrative case investigations.
- Number of criminal cases referred to prosecution; number indicted; number convicted or acquitted.

The Agency submitted the completed PAQ in the OAS ahead of schedule, and the Auditor received an email notification on 6/10/19 that a PAQ has been submitted for Minnie Rogers Juvenile Justice Center and is ready for the Auditor's review. This date began the desk review phase of the pre-onsite audit, and the Auditor immediately began reviewing the answers the Agency provided in the PAQ and the documentation (policies, procedures, forms, supporting documents, MOU's, logs, reports, etc.) submitted. The Auditor submitted two Issue Logs to the PC during the pre-onsite phase, as described below:

- 1st Issue Log sent on 6/12/19, and response received on 6/14/19
- 2nd Issue Log sent on 6/24/19, and response received on 7/3/19.

All the questions and/or issues the Auditor discovered during the pre-onsite desk review were resolved before the onsite, and each required follow up documentation and/or explanations that were provided either by the PREA Coordinator or Casework Manager.

During the pre-onsite phase of this audit, the Auditor made external phone contacts with the following local advocacy groups that the MRJJC has agreements with for residents who have experienced sexual abuse:

- The Executive Director of the Garth House (Mickey Mehaffy Children's Advocacy Program, Inc.); and
- A Crisis Specialist from the Rape and Suicide Crisis of Southeast Texas, Inc.

The Auditor also interviewed over the phone a SANE nurse that has a contract with the hospital (Baptist Hospital of Southeast Texas Beaumont) that a resident from the MRJJC would be referred to for a forensic exam (SANE/SAFE). The SANE nurse is directly employed by the Child Abuse Forensic Services, Inc. Additionally, the auditor reached out to the interpreting service used by the Agency, Abshire Interpreting Services, and the Auditor verified the services that Abshire Interpreting can provide to a resident of the MRJJC are sufficient to the requirements of the applicable PREA Standards.

The Auditor conducted a search on the world wide web of the Agency/Facility and found the following information:

- The Jefferson County Juvenile Probation Department's agency website: https://co.jefferson.tx.us/juvenile/Main.htm. The website includes names of the top administrators of the agency; links to the Texas Probation Association, Texas Juvenile Justice Department (TJJD), Inspire

Encourage Achieve Organization (IEA), and Ben's Kids; the agency's mission statement, and PREA related documents.

- Texas Juvenile Justice Department (TJJD) website: (http://www.tjjd.texas.gov/facilityphotos/1231001/default.aspx) and (http://www.tjjd.texas.gov/publications/other/facilityinfo.aspx?ID=fc6 5ulxLULLxspRnbBH/wWy0HP9zBuXzvf5kDg07n/MAPzjwE0JIiw==). This TJJD web page includes seven pictures of the inside of the MRJJC, verification that the MRJJC is certified by TJJD (Facility ID #1231001), contact information for the Detention Superintendent, general information related to the facility characteristics, educational services, medical and mental health services, number of restraints, and resident programs.

- MRJJC facebook page: https://www.facebook.com/pages/Minnie-Rogers-juvenile-justice-center/1 87222804671650. The Facility's facebook page includes mostly staff pictures and staff related events (i.e., staff retirement), and the last post was from February of this year. The Auditor confirmed that the Agency's page does NOT include any pictures of residents or information related to residents, such as identifiers or private/confidential information.

Additionally, the Auditor reviewed the websites for the Rape and Suicide Crisis of Southeast Texas (RSCST); the Garth House (GH); Abshire Interpreting (AI); Inspire, Encourage, Achieve; and the agency's corresponding website addresses are copied below:

- RSCST: http://www.bmtcoc.org/list/member/rape-suicide-crisis-center-of-southe ast-texas-inc-2945
- GH: https://www.garthhouse.org/
- AI: https://www.alignable.com/beaumont-tx/abshire-interpreting-services
- https://www.ieainspires.com/

The Auditor also reviewed the TX Family Code, Chapter 261, to review the corresponding child abuse reporting laws, on the following State website:

- https://statutes.capitol.texas.gov/Docs/FA/htm/FA.261.htm

Periodically throughout the entire audit process, the Auditor checked the P.O. Box used for the Auditor Notice forms for any correspondence, and at no time was such a correspondence mailed to the Auditor.

Onsite Audit Phase

The onsite portion of the audit was conducted on July 24th, 2019 through July 26th, 2019 by the Auditor. During this time the auditor inspected the entire MRJJC, conducted 31 total staff interviews and 11 resident interviews (to include one targeted resident); conducted an entry and exit meeting; requested to observe an intake; observed surveillance video of male showers and unannounced rounds; conducted a test call with the TJJD Hotline; and reviewed personnel staff files and training files, investigative files, resident detention files, grievances, mental health referrals, and contractor and volunteer files. The Auditor utilized the PREA Audit for Juvenile Facilities Documentation Review forms for all file reviews, and this form documented the PREA Standard requirements of Standards §115.317, §115.331, §115.332, §115.334, §115.335, §115.333, §115.341, and §115.381.

The onsite phase began with an initial entrance briefing on 7/24/19 at approximately 8:30am, and in the briefing was the Auditor, the Agency's Director (Chief Juvenile Probation Officer), PREA Coordinator (who is also the Detention Superintendent), Casework Manager, and two Casework Supervisors. The meeting was conducted in a large room in the administrative area, across from the Director and his assistant, and this is the same room that the Auditor used throughout the onsite audit to review documents and interview administrative staff. During the meeting, the PREA Coordinator (PC) provided the Auditor with the MRJJC Daily Detention List (roster) for 7/24/19 at 00:00 to 7/25/19 at 00:00 and the Facility's Juvenile Supervision Officer (JSO) July 2019 schedule. Additionally, it was reported to the Auditor by the PC that the facility currently has a resident who identified prior sexual victimization in the community during the resident's intake screening, when staff conducting the Facility's Behavioral Screening form, and that this was the only targeted resident currently in the facility. The current population was reported to be at 13 residents, with three male residents assigned to Bpod, six male residents assigned to Cpod, and four female residents assigned to Fpod. It was arranged that all random staff interviews and all resident interviews would be conducted in a private (but on camera) counseling room near the Central Control room. It was also established that a staff member would remain outside the door for security and escorting purposes, and that resident interviews would begin after the facility inspection. Furthermore, the Auditor advised the administrative team that if he is made aware or observes any PREA Standard violation or issue while onsite, that he would address the issue with the PREA Coordinator or another administrative staff member.

After this initial briefing concluded, the PC escorted the Auditor to the secure facility for the facility-wide inspection. The inspection began by walking into the visitation area, which are individual no-contact visitation rooms. Next, the education area was inspected, which were classrooms that were empty due to school not being in session in the summer. It was reported by the PC that the MRJJC contracts with Beaumont Independent School District for teachers, and that no school is in session during the summer months. The Beaumont ISD calendar is the same calendar that the MRJJC uses for their education programming. The same hallway that contained the educational classrooms also included a pharmacy room, medical room, four medical isolation rooms, and counseling rooms that are all on surveillance camera. The PC advised during this time of the inspection that after their last PREA Audit in 2016, four cameras were added to the counseling rooms to increase the overall safety of the facility. The PC then escorted the Auditor out of the hallway into a larger, wide hallway that on one side the Auditor observed the PC's and Supervisor's offices and on the other side were six holding rooms (dry rooms that did not include a sink or toilet), the library, and the dining hall. It was explained to the Auditor by the PC that the grievance/sick call box is located in the dining hall, and the Auditor verified this information and verified that all residents have access to this room three times a day (for each of the three meals- breakfast, lunch, and dinner). The grievance process was described to the Auditor as a process in which a resident can write down a concern or grievance, and place it in the Grievance Box or give to a staff member to be delivered to the Grievance Officer or placed in the Grievance Box (with the Grievance Officers being either the Detention Superintendent or Casework Supervisors). The next area inspected was a large open dayroom area in between two Dorms (in between Dorm #1 and Dorm #2). This large area includes a sitting area, an air hockey game, and two outside recreation areas on either side. At this time during the inspection, the Auditor observed two volunteers (from the Foster Grandparents Program), one male resident (reported to be from Bpod), and one staff member sitting in the large dayroom area. The PC then walked with the Auditor into Dorm #1, which includes three housing areas or PODs (Apod, Bpod, and Cpod). Each POD included 8 single occupancy resident rooms, and Apod and Cpod included a separate individual shower area, while Bpod did not include a shower area. The Auditor observed that Apod was empty and the PC advised that the only PODs in Dorm #1 that are currently being used were Bpod and Cpod. The Auditor observed the shower area and the rooms of the empty POD and no issues

were noted. The next POD the Auditor and PC walked into was Bpod, and in this POD the Auditor observed two residents sitting in the dayroom area with two staff member supervising. The Auditor inspected each resident's room, and he noticed a Resident Handbook in the rooms. The Auditor introduced himself to the staff and residents on the POD, and then walked into the third POD in Dorm #1, Cpod. Cpod had four residents on the POD in the dayroom watching TV and one resident in his room sleeping in, as reported by the staff working the POD. Supervising the residents on Cpod was one staff member. This completed the inspection of Dorm #1, and the next area inspected was Dorm #2. Dorm #2 is the exact same mirror image of Dorm #1, except the PODs are labeled as: Dpod, Epod, and Fpod. Dorm #1 included the four female residents, which at the time of the inspection, the female residents were reported by the PC as being housed on Fpod but programming on Epod. The inspection of Dorm #2 first began with a walk through of Fpod, which as stated earlier, is the same mirrored construction as Dorm #1. Fpod included an individual shower area and eight single occupancy rooms. The next area inspected was Epod, which included the four female residents sitting at the table coloring and one staff member supervising. An announcement was made to alert the female residents that a male was entering the POD, and when on the POD, the Auditor introduced himself to the residents and staff. The Auditor also observed that Epod did not have a shower area- only 8 individual resident rooms. The last POD observed was Dpod, which was empty and included 8 rooms and an individual shower area. This concluded the inspection of the six housing units of the MRJJC, and the Auditor confirmed that there are 48 single occupancy rooms on six PODS and four individual shower areas on the associated four PODs. Additionally, the Auditor confirmed during the inspection that each POD had two cameras that were angled toward the dayroom areas, and each resident in the facility was being directly supervised by at least one staff to a four resident ratio. The next area inspection was the library, which included a phone for residents to use to contact the Texas Juvenile Justice Department (TJJD) to report any type of abuse, neglect, or exploitation (or any other concern). This phone is considered the TJJD Hotline phone, and when the phone is picked up, the call is automatically routed to a TJJD Hotline operator (an external agency). Furthermore, pursuant to TAC §358.340- Reporting of Allegations by Juveniles (Effective Date: 3/1/16):

- Right to Report:
Juveniles have the right to report to TJJD allegations of abuse, neglect, or exploitation and the death of a juvenile. During orientation to a facility or program, juveniles must be advised in writing of their right to report allegations under this subsection and TJJD's toll-free number available for reporting allegations under this subsection.

- Policy and Procedure:
Departments, programs, and facilities must have written policies and procedures that provide a juvenile with reasonable, free, and confidential access to TJJD for reporting allegations.

- Access to TJJD.
Upon the request of a juvenile, staff must facilitate the juvenile's unimpeded access to TJJD to report allegations.

The Auditor conducted a test call to the TJJD Hotline, and the call was completed successfully with no issues to note. The PC then walked the Auditor to the intake area of the facility. This area is a hallway with a laundry room and closet doors on one side and two intake rooms on the opposite side. The Auditor observed both intake rooms, and each room was identical to the other. The rooms include an office area with a desk (a chair on either side of the desk), a camera angled toward the office area, and a shower room that is off camera view. It should be noted that later in the inspection, the auditor viewed the two

intake camera videos from the Control Room and verified that both intake shower rooms are off camera. The next area inspected was the laundry room that included two rooms- a room for the laundry that was on shelves and a room that had the washer and dryers. This area was also observed by the Auditor as being on camera. The sally port was the next area inspected, in which there was a mantrap (two doors and a small hallway) to walk through to access the sally port. The sally port and mantrap locations were also observed by the auditor to be monitored by surveillance cameras. The last area of the facility inspected was the Control Room. The Control Room is located at the front of the facility, and it had tinted windows that you cannot see in but can see out. This room is constructed in such a way as to provide the Control Room Operator direct line of sight, through the tinted windows, of the wide hallway inside the facility, the medical/education hallway, and the isolation rooms; as well as on the opposite side of the Control Room, Control Room staff are able to view, through the tinted windows, the front public entrance into the MRJJC. The Auditor also observed that the Control Room Operator unlocked the Control Room door electronically to allow the Auditor and Superintendent access. The Control Room had six video screens displaying multiple camera views simultaneously. At this time, the Auditor observed the camera views of the housing areas (PODS) and the intake rooms, and he was able to clearly observe that each shower area in the facility was off camera view and that each resident's room toilet and sink area was completely off camera view. On the housing units, the camera angles on the PODs only provided a view of the resident doors, not inside the rooms themselves. The auditor observed a large 56" TV monitor in the Control Room that had multiple facility cameras displayed on the screen. In the Control Room, the Auditor also verified that the detention resident files were securely maintained in a secure filing cabinet next to where the Control Room operator sits.

Throughout the facility inspection, the auditor introduced himself to staff and residents and explained why he was onsite- conducting a sexual safety inspection and auditing for PREA compliance in practice, policies, and procedures. The auditor asked some of the residents during the facility inspection if they were aware of what PREA is about, and the residents informed the auditor that they knew about PREA and their rights. The auditor had short, informal conversations with staff and residents throughout the inspection walk through, and everyone the auditor talked with was welcoming and knew why the auditor was there. The auditor also noticed throughout the inspection TJJD Abuse, Neglect, and Exploitation signage, PREA related signage about zero tolerance and ways to report sexual abuse or sexual harassment, and the Auditor Notices that were posted in 41 locations inside and outside of the secure facility. The Auditor did not note any blind spots that raised a concern at the time of the inspection, and it was reported by the PC that the facility has in operation 89 cameras and that their camera software was just recently upgraded. The Auditor was provided access to view the camera system in the Control Room, in the Detention Superintendent's office, and in the Casework Supervisor's office. Each monitor that the Auditor viewed the facility cameras on provided a clear and sharp image of the area being monitored. The Casework Supervisor and Superintend advised the auditor that their latest video system upgrade now provides the facility with the capability to continually record up to 3 months of video per DVR and sometimes up to 4 months. This allows the facility to review incidents that were not saved on a different media source, other than the automatically saved DVR, up to 3 to 4 months prior to the current day of the review. The Superintendent advised that the cameras only record when there is movement, and therefore this makes the extended record time possible. The Auditor also was advised by the Detention Superintendent and Casework Supervisor that all serious incidents and investigations are recorded on either a thumb drive and/or saved on the county's secure network.

The next phase of the onsite was interviewing residents and staff. The population at the time the auditor was onsite was 13 residents, 9 males (3 assigned to Bpod & 6 to Cpod) and 4 females (all on Fpod). The Auditor was advised during the initial meeting on day one that the facility had one targeted resident- a

resident who identified as a victim of prior sexual victimization while in the community during the intake risk screening process. The Auditor requested to review the Behavioral Screens (risk screening, as related to PREA Standard §115.341) of each resident interviewed (9 out of the available 13 screening forms) in order to verify that there was only one resident whose risk screening indicated that they met the criteria of a targeted resident, the criteria as listed below:

- resident/s who reported sexual abuse;
- resident/s who disclose prior sexual victimization during risk screening;
- resident/s who identify as lesbian, gay, bisexual, transgender, or intersex (LGBTI);
- resident/s who are disabled or limited English proficient (LEP); and
- resident/s in isolation.

Upon the Auditor's review of the nine (9) Behavioral Screenings, the Auditor confirmed that the resident who the Agency identified as being a victim of prior sexual victimization in the community, this resident's Behavioral Screen did in fact indicate that said resident was a victim of sexual abuse prior to being admitted into the facility. Additionally, the auditor confirmed that the remaining 8 resident Behavioral Screenings did not indicate that any other resident met any of the criteria of a targeted population to be interviewed.

The Auditor randomly selected 10 residents to be interviewed from the facility's Daily Detention List and asked each resident the PREA Random Resident protocol questions. The selection of residents represented a sample from each housing unit who were of varying ages and lengths of stays- two out of the three residents assigned to Bpod, 5 out of the 6 assigned to Cpod, and 3 out of the 4 assigned to Fpod. The residents with the longest length of stay, of approximately 4 months, and with the shortest length of stay, of approximately a week, were included in the random sample of residents, and the sample also included the youngest resident to the oldest (ages ranging from 12 to 16 at the time of the onsite). The Auditor selected the last two residents that were not randomly selected as alternates in case a resident refused to be interviewed. One resident randomly selected did in fact refuse to be interviewed, stating to the staff member that the resident just did not want to, and one alternate from Bpod was added to the randomly selected resident sample. As a result, the Auditor conducted the following resident interviews:

- Out of 13 available residents in the MRJJC, ten (10) were randomly selected from the facility's Daily Detention List (resident roster for 7/24/19-7/2/19) and interviewed by the Auditor (77% of the total resident population).
- There was one targeted resident that was interviewed by the Auditor, and it should be noted that this resident is not included in the total number of random interviews, even though this particular resident was asked the victim of prior sexual abuse and random resident questions.
- The Agency reported to the Auditor during the onsite that they did not have any other targeted residents available, and the Auditor verified this every day of the onsite by asking the PC, reviewing all interviewed resident's Behavioral Screenings, and through the interviews that were conducted.

The Auditor interviewed all residents in a counseling room that was near the Central Control room, down a hallway across from the classrooms and next to the medical rooms. The counseling room had one camera that was monitored by Central Control and a staff member was positioned outside the room on the opposite side of the hallway for security and escorting purposes. The Auditor provided the PC a list of the randomly selected and targeted residents that the Auditor requested to interview, and the PC arranged that each resident would be escorted to the Auditor's location. Each interview began with an

introduction and the Auditor explained that the resident was not in any type of trouble. The Auditor communicated that their participation in interview is strictly voluntary and that they can refuse to participate or refuse to answer at any time. It was also explained to each resident that the information from each interview will remain confidential unless the resident says anything about hurting themselves, hurting others, or escaping; in which the Auditor explained that he would have to report this to an administrator within the Department. Additionally, the Auditor described that he would be taking notes throughout the interview, and that these notes are only to assist the Auditor with remembering the answers provided and would not be shared with the Agency. The Auditor explained that if any of the questions during the interview make them feel upset or uncomfortable, that a Mental Health Provider can be provided. Lastly, it was explained that the information in the Auditor's final report will not include any type of identifiers, and that if the resident experiences any negative consequences for talking to the Auditor, such as retaliation or threatened retaliation, to contact the Auditor and/or call the TJJD Hotline. Throughout each interview, the Auditor documented his notes in a blue notebook, and after each interview, he thanked each resident for their participation.

After the resident interviews were completed, the Auditor began specialized staff and random staff interviews. The random staff interviews were conducted in the same counseling room as where the resident interviews were conducted, with the only difference being that a staff member was not assigned to wait outside the room. Out of the 27 certified JSOs employed by the MRJJC during the onsite visit, 12 JSOs were randomly selected by the Auditor to be interviewed using the PREA Random Staff Questions (44%), and 25 specialized staff were also interviewed using the applicable PREA questions. The 12 randomly selected JSOs were selected as a representative sample of JSOs who work all three shifts in detention- the 1st shift (7a-3p), 2nd shift (3p-11p), and 3rd shift (11p-7a); and each staff member was selected from the JSO Schedule for July 2019. Three staff were selected from the 3rd shift, 4 were selected that work the 2nd shift, and 5 were selected that work the 1st shift. Thirty-seven (39) total interviews were conducted by the Auditor to determine PREA Standard compliance in practice and operation for the applicable standards. The interviews of staff conducted by the Auditor are explained in more detail below:

- 12 Random Staff out of 27 (44%)
- 27 Specialized Staff*
- 39 Total Staff Interviewed

Breakdown of Specialized Staff Interviews:

- Agency Head (Director of JCJPD): 1
- Detention Superintendent: 1
- PREA Coordinator: 1
- Human Resource Staff: 1
- Contract Administrator: 1
- Volunteers: 3, two mentor based- Fostering Grandparents Program & one mentoring/counseling based- Inspire Excel Achieve organization
- Contractors: 5
- Intermediate or Higher Level Staff: 2
- Medical Staff: 1
- Mental Health Staff: 1
- SANE/SAFE Nurse: 1
- Investigative Staff: 1

- Sexual Abuse Incident Review Team: 1
- Staff Charged with Monitoring Retaliation: 1
- Staff who perform screening for risk of victimization and abusiveness: 1
- Supervising Staff of Residents in Isolation: 1
- First Responder Staff (certified JSO staff member): 1
- First Responders, non-security staff: 2
- Intake Staff: 1
- Non-medical staff involved in cross-gender strip or visual searches: 0 (n/a- per agency policy, only medical staff are able to conduct such a search).

-TOTAL SPECIALIZED: 27

(*NOTE: Two of the specialized staff interviewed were responsible for more than one of the specialized staff duties: therefore, the number of specialized staff interviews presented in the above breakdown exceeds the number of specialized staff interviewed).

The onsite documentation review was conducted by the Auditor in the large room where the initial meeting was conducted. The PC and Casework Manager supplied the requested files, and both administrators assisted the Auditor with searching for the required documents in the files. The first files reviewed were the resident files, which included a sample of 9 out of the 13 current residents in detention at the time of the audit (a representative sample of 70% of the total population). The Auditor utilized the "PREA Audit- Juvenile Facilities Documentation Review- Resident Files/Records" form in order to document the requirements of PREA Standards: §115.333, §115.341, and §115.381. The information ascertained from each file included, but was not limited to:

- Resident's date of birth & date of admission;
- PREA Intake Screening within 72 hours of admission;
- Periodic Reassessment during the resident's detention stay;
- PREA information during the intake process;
- PREA comprehensive education within 10 days of intake; and
- The date and time of each of time sensitive PREA requirements.

Staff personnel and training files were also reviewed by the Auditor while onsite, with the assistance of the Casework Manager- who helped with identifying where certain applicable documents were located in each file. The Auditor used his randomly selected staff interview list of 10 staff to select 8 randomly selected employee files (out of a possible 27 current staff- 30%) to review for PREA compliance as related to the following PREA Standards: §115.317, §115.331, §115.332. §115.334, and §115.335. This document review and analysis was documented on the "PREA Audit-Juvenile Facilities Documentation Review- Employee Files/Records" form. The form included the Auditor documenting the following information:

- Staff Name and Title;
- Date of Birth and Date of Hire;
- Either a new hire, promotion, current employee, or part-time employee;
- Either a volunteer, intern, or contractor;
- Military DD-214 Honorable Discharge, if applicable;
- Administrative Adjudication Checks;
- Criminal History Check;

- Child Abuse Registry Check;
- Institutional Reference Check;
- 5 Year Criminal History Check or FBI Rap Back Electronic Notice System or Similar;
- PREA Training Documentation;
- PREA Acknowledgement Form Signed;
- Specialized PREA Training, as applicable;
- PREA Refresher Training Every 2 Years;
- Refresher Info Every Other Year Provided; and
- The date and times of all applicable information as listed above.

Furthermore, the Auditor reviewed the criminal history checks, child abuse registry checks, and PREA training verification forms for the following contractors and volunteers (4 contractors out of 37 total, 11%) while onsite:

- One contracted Doctor
- Two contracted nurses
- One volunteers of the Grandparents Fostering Program

It should be noted that the agency reported in the PAQ that they had a total of 51 volunteers and contractors; however, after a comprehensive analysis of the supplementary documentation provided to the auditor by the agency of PREA training acknowledgement forms, it was discovered and verified that the actual number of contractors and volunteers was 37. The agency provided a list of names for each contractor and volunteer that included 37 names and a short description of each contractor's role in the MRJJC. Below is a breakdown of the number of contractors and volunteers:
- 12 teachers with BISD;
- 4 medical contractors (2 Doctors & 2 nurses); and
- 21 volunteers.
- Totaling: 37

The PREA Coordinator also provided the Auditor with the facility's Grievance Log for 2019, which included a total of nine (9) grievances submitted. The PC advised that the facility has not received a grievance in the past 12 months alleging sexual abuse or sexual harassment, and this was verified by the Auditor upon review of the grievance log attached in the PAQ and the 2019 grievance log provided onsite, which both items did not reflect any such grievances being submitted. The Auditor randomly selected three (3) grievances to review for sexual abuse or sexual harassment allegations (33%), and the PC provided the Auditor with each original grievance form. Upon review, all the grievances reviewed were not related to sexual abuse or sexual harassment. The Auditor also reviewed fourteen (14) randomly selected disciplinary seclusions (isolations) from the past 12 months while onsite in order to verify that the facility has not placed a resident on such a seclusion for being involved in an incident of sexual abuse or sexual harassment. Upon review, the Auditor determined that all 14 did not include an incident of sexual abuse or sexual harassment. The Auditor was also provided the Facility's Protective Isolation log for the past 12 months, and the log did not show that a resident was placed on such an isolation in the past 12 months.

Additionally, during the onsite visit, the Auditor watched the PREA video that is used by the MRJJC to educate all residents on the comprehensive PREA educational requirements of Standard §115.333. The video is a TJJD video that is titled "Safeguarding Your Sexual Safety: A PREA Video Orientation Video." Additionally, upon the Auditor reviewing the Agency's "Year-Over-Year Analysis of Sexual Abuse and

Sexual Harassment Data" from 2013 – 2018 that is posted on the Agency's website, the Auditor learned that there was one allegation of staff sexual misconduct from 2016. The Auditor discussed this allegation with the PC, and the PC provided the Auditor with the investigation file of this allegation and a verbal summary of how the investigation was conducted and the disposition. The file included an investigative report, related policies, witness statements, termination documents, and TJJD and law enforcement notification documentation. Further information regarding the Auditor's review and analysis of the investigation from 2016 is provided in the explanation of determination of Standard §115.387 of this report. It should be noted that the Agency reported to the Auditor in the PAQ and the PC advised the Auditor while onsite that they have not had an allegation of sexual abuse or sexual harassment since the 2016 investigation that is described above. This was verified by the Auditor through interviews with Agency staff and residents, a comprehensive review and analysis of all related documents supplied to the Auditor by the Agency (i.e., personnel files, investigative files, data reports, grievances and grievance logs, disciplinary reports, Jefferson County Juvenile Probation Annual Report for 2017 and 2018, and other related documents documented throughout this report), a review of all associated aggregate data the Auditor found on the Agency's website, and through the Auditor contacting Just Detention International (JDI / https://justdetention.org/) to ensure no allegations of sexual abuse or sexual harassment were reported to this health and human rights organization. An affiliate with JDI confirmed through a phone conversation with the Auditor that no such allegations have ever been made to their organization.

While onsite, the Auditor also reviewed surveillance video of unannounced rounds for each of the three shifts- 7am to 3pm, 3pm to 11pm, and 11pm to 7am. The Casework Supervisor allowed the Auditor to review each unannounced round conducted on the Supervisor's office computer, and each round showed an upper-level supervisor/manager conducting the rounds and inspection of the entire facility. The Auditor paid close attention and verified that each round clearly showed that the supervisor or manager performed the rounds where residents were housed, in which the video clearly displayed such action. Additionally, the Detention Superintendent/PREA Coordinator allowed the Auditor to review surveillance video from a previous day's shower time for the male residents. This was used by the Auditor to verify that all male residents were able to shower and change without being on camera view, and furthermore, this also verified that residents were not being observed by staff of the opposite gender during shower times. During each camera review event, the Auditor initiated informal conversations with the PC and Casework Supervisor, and both staff members explained that the facility recently upgraded their computer software program that has allowed for an enhancement of video clarity and recording capabilities. The Auditor was able to view the camera displays on each of the supervisor's computers, and the video quality was extremely clear and there was no video lag that was observed by the Auditor.

Lastly, the Auditor conducted an exit briefing with the administrative team from the MRJJC. In attendance were: The Director, the Detention Superintendent/PREA Coordinator, the Casework Manager, and two Casework Supervisors. The Auditor began the meeting providing the administrators with an overview of the onsite audit- explaining his analysis and assessment of the level of sexual safety in the facility, as related to the 41 PREA Juvenile Standards. The Auditor was able to determine through the onsite PREA compliance visit that the Agency has institutionalized a strong PREA culture in their facility, and no deficiencies of PREA related practices were observed by the Auditor during the onsite. The Auditor discussed three recommendations of enhancing best practices related to PREA Standards, which were as follows:

- Adding documentation on the Facility's Behavioral Screening form that indicates if a child requested to have a follow-up with mental health or medical (as pursuant to §115.341 and §115.381;

- Revising the title of the Facility's PREA Orientation form to: "Comprehensive PREA Education." It was explained by the Auditor that this change in title may help to distinguish the difference between the PREA Orientation provided during the intake process {pursuant to §115.333 (a)} and the PREA Comprehensive Education provided within 10 days {pursuant to §115.333 (b)}.
- Adding the Moss Group Cross-Gender and Transgender Pat-Down search training video to the training curriculum already being used by the Agency, pursuant to §115.315 (f).

As a follow-up, it should be noted that the Agency provided the Auditor an email and related follow-up documents after the onsite demonstrating that each of the above recommendations were fully implemented:

- Added a section of the Behavioral Screen to include: If yes (for prior sexual victimization/abuse), does the juvenile want MHP follow up? Yes / No
- Revised the Facility's PREA Orientation form to "Comprehensive PREA Orientation."
- Adding the Moss Group training video to the next training, per the Casework Manager.

The Auditor expressed his appreciation for the Agency having him onsite and the assistance everyone provided during the pre-onsite and onsite phase of the audit. Additionally, the next steps of the audit process was explained by the Auditor, to include:

- a final review of all information from the pre-onsite and onsite to determine compliance with each provision of each PREA Standard;
- the high likelihood of the Auditor contacting the PC to follow-up on any clarification or additional information or documents that may be needed for the compliance review;
- the Auditor's probationary status and how the audit report will be reviewed by the PREA Resource Center;
- the date the interim and/or final report is due to the facility (by 9/24/19); and
- the corrective action process.

In conclusion, the exit meeting ended with no issues to note, and the administrative team thanked the Auditor for his auditing services.

Post-Onsite Audit Phase

After the onsite, the auditor immediately began triangulating and analyzing all the data provided to measure the MRJJC's compliance with each element of each PREA standard. All applicable policies, documents, memos, forms, issue log responses, interview notes, website data, PAQ provided information and documentation, training records, personnel records, resident files, MOU's, contracts, email communications, phone interviews, Handbooks (both pre and post), investigation documents, logs, post assignments, resident rosters, staff schedules, Staffing Plans and Reviews, and facility schematics were extensively examined and reviewed to assist the auditor with his final determination of if the agency is exceeding, meeting, or in non-compliance with each PREA standard. During this phase, the auditor communicated with the agency's PREA Coordinator and Casework Manager by email and phone in regards to seeking further clarification and follow-up documentation related to PREA standards that the auditor needed more information on. The PREA Coordinator and Casework manager were extremely accommodating and provided the auditor with additional documentation and explanations of practice as needed through this process.

Final Conclusion:

The auditor determined that the agency exceeds the requirements of four (4) PREA Standards, meets the requirements of 35, and did not meet the full requirements of two (2)- §115.313 {specifically subsection (d)} and §115.388. This determination of non-compliance for the two standards activated the need for corrective action. Furthermore, as noted below in the Summary of Auditor Findings section of this report, the agency provided the auditor with a sufficient corrective action plan and proof of full implementation of the plan to permit the auditor to determine that the agency is now in full compliance with all PREA standards.

AUDIT FINDINGS

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

DESCRIPTION OF FACILITY CHARACTERISTICS

The Jefferson County Juvenile Probation Department (JCJPD / "Agency") is one building that operates the Minnie Rogers Juvenile Justice Center (MRJJC), which includes one 48 bed secure pre-adjudication juvenile detention center ("Facility"). The MRJJC was opened June 24, 2002, and the Agency is located at 5326 Hwy 69 South, Beaumont, Texas 77705. The Facility is divided into two separate but identical Dorms, Dorm #1 and Dorm #2, with each Dorm including three PODs, or housing units. Per the Texas Administrative Code, the definition of a single-occupancy housing unit is: "A housing unit that is designed and constructed with separate and secure individual resident sleeping quarters and that includes appropriate sleeping, sanitation, and hygiene equipment or fixtures." Additionally, per the FAQ from the PRC website, the PREA definition of a housing unit corresponds with the TAC definition, and the six (6) PODs in the facility (three per Dorm) shall be considered housing units in this report. Each POD, or housing unit, includes 8 single-occupancy resident rooms that include a bed, sink, toilet, and window. The facility is comprised of a large multi-purpose area, two secure exercise/basketball courts, a pharmacy, medical exam room, and four classrooms (with one of the classrooms being a computer lab), five intake holding rooms, PREA Coordinator/Detention Superintendent Office, Court Room, Visitation Area, and a secure drop off area for law enforcement (sally port). Additionally, the Facility also has four janitorial closets, with each closet requiring a key to open and a camera. Each POD has utility closets, laundry rooms, supply rooms, and a dayroom is on each POD.

The MRJJC accepts juveniles referred by the Beaumont Police Department, Jefferson County Sheriff's Department, the Jefferson County Juvenile Probation Department, other law enforcement agencies as applicable, and from five surrounding county Juvenile County Departments (as contract residents). The five surrounding counties the Agency contracts with are: Chambers, Tyler, Liberty, Orange, and Jasper. Each contract for detention services includes a PREA Article, Article XII, explaining the PREA Standard requirements of the Agency. The Juvenile Board of Jefferson County is set forth in Section 152.1291 of the Human Resource Code V.T.C.A. and consists of the County Judge and the District and Criminal Judges of Jefferson County. The Juvenile Board evaluates, monitors, and when necessary, recommends modification of all functions of juvenile probation services in accordance with the Texas Juvenile Justice Department (TJJD) Standards. The Board ensures that the Juvenile Probation Department is headed by a single Administrative officer, the Director of the JCJPD, who is responsible to the Board. The Board also ensures that the administrative manual is developed and maintained, which includes policies, procedures, and regulations of the Department. The Jefferson County Juvenile Board controls and supervises the county facility used for the detention of juveniles, the Minnie Rogers Juvenile Justice Center (MRJJC). The Board inspects the facility each year and certifies that it is suitable for detention of children according to the minimum standards promulgated by the TJJD.

Additionally, the Agency and Facility comply with Texas Administrative Code (TAC) Title 37, Chapters 343 and 344. TAC Chapter 343 requires secure juvenile facilities in TX to comply with approximately 142

standards dealing with standards for secure juvenile pre-adjudication detention facilities, and TAC Chapter 344 requires agencies to comply with approximately 44 standards related to employment, certification, and training requirements for all certified Juvenile Supervision Officers (JSOs) and Juvenile Probation Officers (JPOs). Pursuant to TAC §344.620 (10) and §344.622 (4): the purpose and goals of the Prison Rape Elimination Act (PREA) are mandatory training topics for all Juvenile Officers in the State of Texas, both for Juvenile Supervision Officers (JSOs) and Juvenile Probation Officers (JPOs), to gain the applicable state certifications to work with juveniles. Additionally, to be certified as a JSO or JPO in the state of TX, each new employee must pass a State exam that includes PREA related questions before being allowed to supervise juveniles. The MRJJC is inspected for compliance in all applicable Chapter 343 and 344 standards annually by the Compliance and Inspection Division of the Texas Juvenile Justice Department (TJJD).

The Agency publishes an annual report, titled- Jefferson County Juvenile Probation Annual Report 2018 (latest edition). The 2018 Report includes 16 pages of information related to: juvenile board members, referrals by offense, child in need of supervision referrals, court dispositions, MRJJC, detention statistics, Jefferson County Youth Academy, Placements, Service Programs, Inspire-Encourage-Achieve (IEA), MRJJ Award, and Departmental highlights. This report also explains that MRJJC was developed with the capability of expanding by an additional 48 beds if future needs mandated. The Agency's mission statement is documented in the 2018 Report, and states:
"It is the mission of the Jefferson County Juvenile Probation Department, under the direction of the Juvenile Board, to serve the Juvenile Court and be accountable:

-To direct the rehabilitation, education, care, and security of youthful offenders between the ages of 10 to 17;
-To protect the community;
-To be sensitive to victims' issues;
-To address elements in society that contribute to delinquency;
-To provide a better understanding of juvenile delinquency trends through community education; and,
-To continue to recognize the value of research as it relates to the causal factors and supervision methods"

The average daily population in the last 12 months was 17 residents, and the actual detention resident population on the first day of the Auditor's onsite visit of the facility was 13 residents, 9 males and 4 females. There were three male residents assigned to Bpod, six male residents assigned to Cpod, and 4 female residents assigned to Fpod. The current population makeup at the time of the onsite was 77% African American and 23% Caucasian. The Agency documented in the PAQ that they had 331 residents admitted to the facility during the past 12 months, with 182 whose length of stay was 10 days or more in detention and 262 whose length of stay was 72 hours or more. The average length of stay for the resident population was recorded as 20 days. Furthermore, the 2018 Report documents the following annual detention statistics from 2014 to 2018:

- 2014: 225 boys admitted / 109 girls admitted = total of 334 (average length of stay 18 and average daily population 23.
- 2015: 231 boys admitted / 79 girls admitted = total of 310 (average length of stay 16 and average daily population 23.
- 2016: 210 boys admitted / 92 girls admitted = total of 302 (average length of stay 19 and average daily population 25.

- 2017: 240 boys admitted / 86 girls admitted = total of 326 (average length of stay 21 and average daily population 25.
- 2018: 151 boys admitted / 47 girls admitted = total of 198 (average length of stay 19 and average daily population 17.

The Agency reported in the PAQ that they currently have 52 total staff that work for the Agency and 27 certified JSOs that work in the detention center, with 15 of the 27 JSO staff hired in the past 12 months. The MRJJC employs one fulltime licensed Mental Health Provider, who is a Texas Department of State Health Services (TDSHS) licensed Sex Offender Treatment Provider (LSOP) and a licensed Professional Counselor (LPC), as proven by the Agency with TDSHS certification documentation provided to the auditor. Additionally, the Agency contracts with two registered nurses for medical service for residents in the MRJJC. The Casework Manager explained to the auditor that the MHP and contracting nurses are available to the facility 24/7 for any emergency or special situation that requires mental or medical attention. The Beaumont Independent School District (ISD) provides certified teacher who provide educational programming to the juveniles in the Center. In accordance with Texas Education Agency standards (TAC 19.89.1801) the education program was expanded in the Facility to a full school day at the beginning of the 2009 school year. The Auditor verified that all staff and volunteers and contractors who may have contact with the residents have received PREA training and criminal history and child abuse registry checks, as required by the applicable PREA Standards.

The MRJJC is a secure pre-adjudication juvenile detention center that requires direct care supervision of all the residents in the facility. The ratio requirements that the Facility adheres to is one staff for every eight residents (or 1:8) during waking or programming hours and one staff for every sixteen residents (or 1:16) during sleeping or non-program hours. The Facility utilizes 89 cameras that are strategically located throughout the inside and outside of the secure facility that supplement the staff to resident direct line of sight ratio. It was reported by the PREA Coordinator that the video monitoring DVR system can record up to 4 months of video, and that the Director, Detention Superintendent, Casework Manager, and two Casework Supervisors have access to the DVR functions of the video monitoring system. Juveniles that are detained in the MRJJC follow a structured 16 hour day routine which includes educational programming, individual and group counseling time, three hot meals a day that are served in the dining room, personal hygiene, and recreation and large muscle exercise. All residents receive instruction in the core classes of Math, Language Arts, Social Studies, Science, Physical Education, and elective classes. The Agency allows for volunteer groups to work with the residents in detention, such as: Inspire, Enhance, Achieve (IEA); a Chaplain group; and the Fostering Grandparents program. The Chief of the Department informed the auditor that an IEA member is assigned as a mentor to each resident in the facility (except for resident who are charged with serious crimes, i.e., murder), and that the mentors remain in contact with the juvenile after they are released from the Detention Center. Per the IEA website (https://www. ieainspires.com/), IEA – Inspire, Encourage, Achieve, is a Southeast Texas nonprofit organization established in 1997 to help underprivileged youth (involved in the juvenile justice system). Last year (2018), IEA staff and volunteers worked with more than 300 youth in the Minnie Rogers Juvenile Justice Center (MRJJC) as well as with those under supervision of the Jefferson County Juvenile Probation Department, providing counseling and other therapeutic services, including anger management, art and yoga. Staff also provided parenting classes for nearly 75 families who benefited from a supportive network of resources, enabling them to strengthen their parenting skills and develop stronger support systems.

The detention staff (JSOs) provides the juveniles with the care, structure, discipline, and supervision needed to foster growth in their decision making and choice making in the future, per the 2018 JCJPD

Report. The Detention Center uses a level/privilege system which was designed by the detention staff, approved by the Juvenile Board, and implemented. The level system provides motivation for the juveniles to participate in all the components of the program and be rewarded for their positive participation. It also provides for the appropriate consequences for inappropriate behavior.

The MRJJC enhanced their video monitoring capabilities by adding four cameras in each of the counselor rooms after the last PREA audit in 2016, as reported by the PREA Coordinator. The PREA Coordinator also advised the Auditor that the facility recently upgraded their surveillance video software that allows for longer DVR playback and more clarity in the video. It should be noted that the Facility currently has in operation 89 surveillance cameras, with the Central Control room have six monitors (one large 56" monitor) continually displaying a multitude of cameras simultaneously. Additionally, the Casework Supervisor's and Detention Superintendents/PC's offices have video monitors. The Casework Manager advised that the Facility is continually staffed for 40 residents even though in the past 5 years the average daily population of residents has ranged from as high as 25 (in 2016) and as low as 17 (in 2018). During the onsite, the Auditor confirmed that adequate staffing levels were being maintained, with the Facility exceeding the required 1:8 ratio on each of the three resident PODs. Further explanation of how the agency exceeded the minimum staff to resident ratios is described in greater detail in subsection 115.313 of this report. The Auditor also verified that the Facility is able to modify a resident housing assignments, on an as needed basis. For example, during the onsite there were three PODs that were not being used and enough staff in the building to open all three PODs and still remain in ratio. The PC explained that if there ever was a situation in which a resident needed to be removed from the POD due to a safety or security threat, groups of residents or one particular resident could be moved to the empty PODs.

Based upon the pre-onsite review and analysis of Agency policies, procedures, and supplemental documentation and the onsite inspection and review of Facility practices related to PREA, the MRJJC leadership and staff demonstrated a committed to providing the resident in their custody a safe and secure environment. The Agency revealed to the Auditor that there is a culture of sexual safety, and that full PREA compliance is a major goal and priority. Through interviewing residents, the Auditor was able to easily comprehend that the residents in the facility were aware of their PREA rights and the systems in place to report any type of sexual abuse, sexual harassment, retaliation, and staff neglect. Additionally, staff indicated that the Agency has an open door type policy, and that staff are not afraid to report any concerns or allegations directly to Agency leadership. Staff were able to clearly articulate that the Agency has a zero-tolerance against any type of sexual abuse, sexual harassment, retaliation, and staff neglect of any kind and the reporting protocols that are in Agency policy.

AUDIT FINDINGS

Summary of Audit Findings:
The summary should include the number of standards exceeded, number of standards met, and number of standards not met, along with a list of each of the standards in each category. If relevant, provide a summarized description of the corrective action plan, including deficiencies observed, recommendations made, actions taken by the agency, relevant timelines, and methods used by the auditor to reassess compliance. Auditor Note: No standard should be found to be “Not Applicable” or “NA”. A compliance determination must be made for each standard.

Number of standards exceeded:	4
Number of standards met:	39
Number of standards not met:	0

Summary of Audit Findings

The summary should include the number of standards exceeded, number of standards met, and number of standards not met, along with a list of each of the standards in each category. If relevant, provide a summarized description of the corrective action plan, including deficiencies observed, recommendations made, actions taken by the agency, relevant timelines, and methods used by the auditor to reassess compliance.

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

Number of Standards Exceeded: 4

115.321; 115.331; 115.333; and 115.352.

Number of Standards Met: 37

115.311; 115.312; 115.313; 115.315; 115.316; 115.317; 115.318; 115.322; 115.332; 115.334; 115.335; 115.341; 115.342; 115.351; 115.353; 115.354; 115.361; 115.362; 115.363; 115.364; 115.365; 115.366; 115.367; 115.368 115.371; 115.372; 115.373; 115.376; 115.377; 115.378; 115.381; 115.382; 115.383; 115.386; 115.387; 115.388; and 115.389.

Number of Standards Not Met: 0

Click or tap here to enter text.

Summary of Corrective Action

As noted in the explanation of determination sections for both §115.313 and §115.388, the agency has been found by the auditor to be in full compliance with the corrective action already fully implemented by

the agency before the completion of this final report. Detailed explanation the non-compliance and corrective action taken is provided below:

§115.313:
The MRJJC reported to the auditor that they did not complete a formalized Staffing Plan Assessment in 2017 or 2018; although during those years, the Superintended (who is the PREA Coordinator) and the Chief of the agency acknowledged in their interviews that the staffing plan (Policy 3.8)- as related to staff patterns, monitoring technology, and the allocation of agency resources to commit to the staffing plan to ensure compliance- was continuously assessed and evaluated by the management team on a daily basis. Furthermore, this was verified by the auditor by analyzing the agency's Staffing Plan Policy 3.8, two Staffing Assessment Reports from 2016 and 2019, reviewing 8 randomly selected personnel files that included 8 signed Essential Personnel forms (ensuring staff understand and agree to work during emergency situations), reviewing data related to average daily populations of the facility and comparing this data to staff schedules for the entire month of July 2019, and through interviewing the Superintendent and Chief of the agency (as explained throughout this standard explanation- each providing testimony that the staffing plan was never deviated and all elements of the staffing plan were assessed on a daily basis since the last PREA audit). Due to the staffing plan reviews not being formally completed in 2017 and 2018, the Auditor determined that the Agency is not in compliance with this particular PREA provision {§115.313 (d)}; therefore, prompting corrective action. During the pre-onsite audit phase, the Casework Manager provided to the auditor an improvement plan to address the non-compliance with this provision to ensure future annual staffing plan assessments will be completed going forward. This plan involves the Superintendent being responsible for updating the agency's Annual Inspection List and emailing it to all Detention Supervisors, the Casework Manager, and the Chief. The Casework Manager confirmed with the auditor that the Superintendent has already updated the annual inspection list with the Staffing Plan Assessment, PREA MOUs, and annual review of SA/SH incidents, and this document was provided to the auditor through an email attachment after the onsite visit.

Ultimately, the auditor determined that in the past 12 months the agency has complied with and institutionalized the PREA staffing plan requirements of §115.313 (d) of assessing, determining, and documenting whether adjustments are needed to the staffing plan, prevailing staffing patterns, the facility's deployment of video monitoring systems and other technologies, and the resources the facility has available to commit to ensure adherence to the staffing plan. The Agency has institutionalized Policy 3.8 (that includes the original staffing plan) and provided the Auditor with their Staffing Plan Assessment from May 21st, 2019, and each document fulfils the requirements of this PREA Standard provision. With the corrective action plan already fully implemented (as determined by the auditor through conversations with the Chief, Casework Manager, and Superintendent and the documentation of the annual list), future staffing plan assessments and other annual reviews and inspections should not be missed.

115.388:
The auditor reviewed the agency's annual report completed in calendar years 2016 and 2019, and each report was found to be in full compliance with the provision requirements of this standard. It should be noted that the agency reported to the auditor that the annual report was not completed for calendar years 2017 or 2018, and due to the annual requirements of this standard, the agency was found to be in non-compliance with this standard therefore prompting the need for corrective action.

During the pre-onsite audit phase, the Casework Manager provided to the auditor an improvement plan to address the non-compliance with this standard to ensure future annual reviews pursuant to this PREA standard will be completed going forward. This plan involves the Superintendent being responsible for

updating the agency's Annual Inspection List and emailing it to all Detention Supervisors, the Casework Manager, and the Chief. The Casework Manager confirmed with the auditor that the Superintendent has already updated the annual inspection list with the following annual PREA requirements and this list was provided to the auditor:

- Staffing Plan Assessment;
- PREA MOUs; and
- Annual Review of Sexual Abuse/Sexual Harassment Incidents.

Ultimately, the auditor determined that for calendar year 2019 the agency has complied with and institutionalized the PREA annual review and report requirements pursuant to §115.388 of reviewing and documenting on a report the data collected and aggregated pursuant to §115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, response policies, and training. The Agency has institutionalized Policy 12.5 (that includes the requirements of the PREA standard) and provided the Auditor with their Annual Review of Sexual Abuse/Sexual Harassment Incidents from May 14th, 2019. It should be noted that this 2019 report fulfils the requirements of this PREA Standard provision for 2019. With the corrective action plan already fully implemented (as determined by the auditor through conversations with the Chief, Casework Manager, and Superintendent and the documentation provided of the annual list), future annual PREA reviews an reports pursuant to this standard and other annual reviews and inspections should not be missed.

Standards

Auditor Overall Determination Definitions

- Exceeds Standard
  (Substantially exceeds requirement of standard)
- Meets Standard
  (substantial compliance; complies in all material ways with the stand for the relevant review period)
- Does Not Meet Standard
  (requires corrective actions)

Auditor Discussion Instructions

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

115.311	Zero tolerance of sexual abuse and sexual harassment; PREA coordinator
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.311 The following is a list of evidence used to determine compliance: - Pre-Audit Questionnaire (PAQ) - Policy 12.5 (Sexual Abuse & Mistreatment) / Revised Date: 09/02/2019 - Jefferson County Juvenile Probation Services (JCJPS) Organization Chart Interviews: - PREA Coordinator Site Review Observations: During the onsite audit, the auditor observed the PC's office, which was located in the Detention Center, and this center location provides the PC with the ability to observe and monitor the daily operations of the program and facility. The PC was the auditors' point of contact throughout the entire audit process, and he also escorted the auditor throughout the MRJJC, including when the facility inspections was conducted and during interviews in the secure facility. The auditor observed that the PC has the ability to freely access all areas of the secure facility and to all areas of the casework and administrative areas. The PC reports directly to the Chief of the Department, and his office was observed by the auditor to be located in the middle of the large hallway when entering the secure facility. Explanation of determination: 115.311 (a): The agency has a written policy that outlines JCJPS's zero tolerance toward all forms of sexual abuse and sexual harassment on page one (1) of Policy 12.5 (Sexual Abuse). This Policy includes a comprehensive plan for how the agency implements the agency's approach and strategies to prevent, detect, and respond to sexual abuse and sexual harassment. Policy 12.5 addresses how the agency strives to prevent sexual abuse and sexual harassment through: - required staffing ratios; - use of surveillance cameras; - the overall structured design of the facility; - ensuring confidentiality; - sexual abuse incident reviews; - criminal history background checks and child abuse registry checks (for all staff, contractors, volunteers, and interns); - orientation and training for all who may have contact with residents; - contract monitoring; and

- intake screening, classification, and resident education.

Additionally, detecting sexual abuse and sexual harassment is addressed throughout Policy 12.5, and this Policy explains the following provisions as related to detection:

- staff, contractors, volunteers, and intern PREA training;
- video monitoring system;
- PREA related signage posted throughout the facility;
- intake screening;
- multiple methods that a resident and a staff member can report incidents of sexual abuse or sexual harassment;
- the agency's grievance system;
- compliance and safety inspections; and
- investigations.

Lastly, Policy 12.5 addresses the agency's methods for responding to sexual abuse or sexual harassment through the following methods:

- multiple internal methods of reporting that are available for residents and staff;
- uniformed evidence protocol;
- disciplinary sanctions for residents and staff who are found to be a perpetrator of sexual abuse or sexual harassment (including notification to law enforcement and the Texas Juvenile Justice Department- TJJD);
- medical and mental health services;
- victim advocacy services;
- confidentiality requirements;
- sexual abuse incident review teams;
- required corrective action, when applicable; and
- data collection and analysis.

Additionally, agency Policy 12.5 provides the PREA definitions of prohibited behaviors regarding sexual abuse and sexual harassment that ensures there are no discrepancies to actions related to sexual abuse or sexual harassment. 12.5 also includes sanctions for those found to have participated in prohibited behaviors, including both resident and staff perpetrators.

115.311 (b):
Per the agency's response in the Pre-Audit Questionnaire (PAQ), JCJPD designated the Department's Superintendent as the agency-wide PREA Coordinator (PC), and his position is included as an upper-level management position on their Organization Chart.

The auditor interviewed the PREA Coordinator (PC)/Facility Superintendent while onsite, and he explained that he has enough time to manage all of the PREA related responsibilities and that he reports directly to the Chief of the Department. As indicated by the agency in the PAQ, the PC advised that the JCJPD does not utilize a PREA Compliance Manager due to only having to operate one facility. The PC described how if he identifies an issue with complying with PREA standard, he would immediately meet with the Chief and Casework Manager to address the issue and discuss how to correct the non-compliance. He advised the auditor that

	a policy may change as a result of a non-compliance issue/s, and that re-training may be incorporated to ensure all staff are made aware and understand the change in policy and procedure. 115.311 (c): N/A The facility reported in the PAQ that they only operate one facility, a pre-adjudication detention facility, and have not designated a PREA Compliance Manager. Conclusion: Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.312	Contracting with other entities for the confinement of residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.312 The following is a list of evidence used to determine compliance: - Pre-Audit Questionnaire (PAQ) - Placement Contracts for 2019 (total of 13) Interviews: - Agency's Contract Administrator Explanation of determination: 115.312 (a): The agency provided in the PAQ that they have contracts with thirteen (13) agencies for the confinement of residents that JCJPD entered into or renewed with private entities or other government agencies since the last PREA audit was completed in 2016. JCJPD provided in the PAQ all thirteen (13) contracts for placement and short-term detention contracts that the auditor analyzed for PREA compliance as related to this provision. Each contract includes a section on PREA, titled- "PREA XII," that requires the contracting agency to adopt and comply with applicable PREA standards. 115.312 (b): Each of the 13 contracts reviewed by the auditor include a requirement for JCJPD to monitor the contractor's compliance with PREA standards. Five out of the 13 contracts are for other juvenile probation agencies to house their delinquent juveniles in the MRJJC, and the remaining eight are contracts for JCJPD juveniles to be placed at post-adjudication type programs. Out of the eight agencies the JCJPD contracts with for placement outside Jefferson County- one agency no longer is operating and three have PREA related statistics and/or PREA Audit reports available on their websites. The auditor interviewed the JCJPD's Contract Administrator, and she explained that she requests PREA related data on sexual abuse and sexual harassment allegations, investigations, and dispositions annually from each contracting agency in order to monitor for compliance with PREA related practices. She advised the auditor that PREA compliance results have been completed for each contract entered into agreement within the past 12 months, and that she would follow-up with a contracting agency, if necessary, to ensure compliance. Furthermore, the Contracts Administrator described to the auditor that all contracted facilities have completed and submitted PREA compliance results to the JCJPD, as required by each contractor's contract. Conclusion: Based upon the review and analysis of all the available evidence, the auditor has determined

	that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.313	Supervision and monitoring
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.313 The following is a list of evidence used to determine compliance: - Pre-Audit Questionnaire (PAQ) - Agency Policy 3.8 (Staffing Requirements) / Last updated: 06/16/2016 - Agency Policy 9.3 (Juvenile Supervision and Movement) - Facility Response to Issue Log- #1 and #2: 115.313 (b) and (d) - Juvenile Supervision Officer Schedule- July 2019 - Minnie Rogers Juvenile Justice Center Daily Detention List (July 24th-25th of 2019) - 2018 Staffing Plan Assessment completed on May 21st, 2019. - 2016 Staffing Plan Memorandum (signed by the Chief and approved by the Juvenile Board) - 2016 Staffing Plan Assessment - Essential Personnel Acknowledgement forms (8 signed forms provided from 8 randomly selected staff personnel files- out of a total of 27 certified staff currently employed at the facility) - PREA Unannounced Rounds Form - PREA Verification of Monthly Unannounced Rounds Form - Jefferson County Juvenile Probation Services Organizational Chart - Texas Administrative Code (TAC) Chapter 343.436 Interviews: - Detention Superintendent, who is also the PREA Coordinator (PC) - Casework Supervisors (two) who conduct unannounced rounds in Detention - Casework Manager who reviews and verifies supervisor unannounced rounds Site Review Observations: During the onsite audit, the auditor observed: - the overall facility layout, including all six (6) housing areas (2 dorms with 3 housing units, or PODS, per dorm, with 8 single occupancy resident rooms per POD); - adequate staffing levels on each housing unit (at least one staff member for no more than 8 residents per housing area); - video monitoring throughout the facility (facility has a total of 89 operating cameras in and around the secure facility); - blind spots that are off camera (i.e., no cameras inside the shower areas or in resident rooms); - the program operations for the first (7a-3p) and second (3p-11p) shifts; and - how the video monitoring system software operates and is saved. The auditor completed a facility inspection with the Detention Superintendent/PC on the first

day of the onsite, and during this time, the auditor was escorted throughout the entirety of the secure facility. Upon walking into the main dayroom area of the secure facility, the auditor observed one male resident talking with two volunteers (Volunteers of the Foster Grandparent Program), with a male staff member in the dayroom supervising the resident. The next area the auditor observed was Dorm 1 that included three male resident PODs (housing units), with eight (8) resident rooms per POD. The PODs in Dorm 1 are designated as: Apod, Bpod, and Cpod. Apod did not have any residents in the POD during the facility inspection, and the Superintendent informed the auditor that Apod was not being used for housing at the moment. The next POD inspected and observed by the auditor was Bpod, with two male residents on the POD sitting in the dayroom playing a game and one male staff member supervising. Lastly, the auditor walked with the Superintendent into Cpod, which had four (4) male residents sitting in the POD's dayroom watching TV and two male staff members supervising. This completed the inspection of Dorm 1, and the auditor and the Superintendent then walked to Dorm 2. Dorm 2 includes: Dpod, Epod, and Fpod; with Fpod being used for housing the female residents, Epod being used to program the same female residents, and Dpod closed/empty. The auditor observed four (4) female residents sitting at a table in the Epod dayroom, drawing coloring pages- with two female staff supervising the residents. Additionally, the auditor observed that Apod, Cpod, Dpod, and Fpod are the only PODs with shower areas, and Bpod and Epod are PODs that can house residents but do not have showers. The shower areas on each applicable POD are individual showers, and the auditor verified that residents are able to shower without being viewed on camera by reviewing male shower times on the agency's surveillance camera system from the previous day. Furthermore, the auditor was provided access to the agency's Central Control room, supervisor's office, and Superintendent's office; in which all rooms/offices have video monitoring capabilities. The Central Control room contains six (6) monitors (including one large 56" monitor), which provides the control room officer the capability to observe multiple cameras at one time. The supervisor's and Superintendent's offices include two monitors that allow the applicable staff member to view surveillance video while still being able to use the other monitor for computer work.

Explanation of determination:

115.313 (a):
The Minnie Rogers Juvenile Justice Center (MRJJC) operates one facility, a secure juvenile detention center, and agency Policy 3.8 provides assurances that the facility has developed, implemented, and documented a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against sexual abuse. The general provision of this plan, as documented in 3.8, is for the MRJJC to establish a written staffing plan, so called the "Safe Housing Staffing Plan," that describes the staffing levels allowed, staffing requirements, security level, and programming schedule of each housing unit. The auditor reviewed the agency's Safe Housing Staffing Plan (Policy 3.8) and confirmed that this plan includes the eleven elements of this PREA provision. In addition, Policy 3.8 provides a comprehensive outline of the following detention staffing and resident dynamics:

- Facility Design Bed Capacity (48)
- Room Assignment Procedures
- Programming Schedule (broken up into: Monday through Friday schedule, weekend schedule, cafeteria meal time schedule, and evening schedule)

- Video Monitoring- each area of the facility that includes video surveillance is documented with the total number of cameras for each location (89 total cameras, as reported by the Superintendent)
- Male and Female Unit (capacities, groups, population, layout, and programming)
- Staffing Schedule (shifts separated into: day, evening, night, control room, and cooks)
- Identifying blind spot areas
- Educational programming for the facility youth
- PREA Supervision Requirements
- Other (explaining the requirement of complying with the staffing plan except during limited and discrete exigent circumstances- with documentation if deviated)

Additionally, the staffing plan requires the following:

- An annual review by the PREA Coordinator to assess, determine, and document adjustments to the Staffing Plan.
- The Superintendent to approve the staffing plan that is developed for each housing unit.
- The Superintendent or designee to review the daily rosters to ensure accuracy and compliance with staffing plan as it relates to placement of juveniles.
- The Superintendent or designee to review and approve the posted staff schedule.

The agency's staffing plan, Policy 3.8, includes procedures
for ensuring that adequate staffing ratios of at least one (1) staff for every eight (8) residents during resident waking hours (1:8) and at least one (1) staff for every sixteen (16) residents during resident sleeping hours (1:16) are maintained at all times, with contingencies for exigent circumstances. The contingencies include, but are not limited to:

- Ensuring the facility wide ratio and the direct supervision ratio during program and non-program hours is maintained at all times, 1:8 and 1:16 respectfully.
- Ensuring at least one male Juvenile Supervision Officer (JSO) and one female JSO shall be on duty any time the facility has at least one juvenile resident.
- Scheduling at least 5 JSO's, a Casework Supervisor, and a control room person for all three shifts- 1st shift (7am to 3pm), 2nd shift (3pm to 11pm), and 3rd shift (11pm to 7am).
- Providing a list of designees that shall be in charge in the absence of the Superintendent: Casework Supervisor, Lead Juvenile Supervision Officer, and Senior Juvenile Supervision Officer on Duty.

Additionally, Policy 9.3 outlines the agency's ability to ensure juveniles are never left unattended in any area inside or outside the facility. This Policy explains that intensive staff supervision is intended to reduce reliance on security hardware (surveillance cameras) and to promote a positive relationship between staff and juveniles as the primary means of control. 9.3 also describes the agency's requirement of having at least one JSO maintaining visual contact with each juvenile, and that staff should not leave their area of responsibility without first informing the Control Center. JSOs are required, per this Policy, to conduct periodic head counts to ensure the earliest possible detection of an absent juvenile, and head counts are also required when transporting residents to one area of the facility to another. Furthermore, this Policy requires that juveniles are never to be left unattended while in a common activity area, and that during program hours, juveniles shall be in constant physical presence of a JSO, unless the juveniles are placed in their rooms, whereas, JSOs will then complete room

observation checks at staggered intervals not to exceed 15 minutes. Audio and video monitors are described to not be substituted for direct supervision of juveniles. The Policy explains that juveniles are never to be allowed to enter the janitor's closet, the kitchen, the property room, or the laundry room. Lastly, 9.3 states that there shall be a minimum of four (4) staff members on duty during waking hours and three (3) during sleeping hours- providing a minimum ratio with the average population of 17 (in 2018) of at least 1:8 and 1:16, respectfully. This Policy describes that if all possible, a JSO of one gender shall not be the sole supervisor of a juvenile of the opposite gender. This was also verified by the auditor when he was onsite, with only male staff supervising the male residents and only female staff supervising the female residents.

Furthermore, the agency documented in the PAQ that since their last PREA audit in 2016, the MRJJC's average daily number of residents as being 22 and the average daily number of residents on which the staffing plan was predicated being 40. The Casework Manager for MRJJC explained to the auditor that the detention center is staffed for an average population of 40 residents, even though the average daily population is 22, in order to ensure adequate staffing levels are maintained at all times, even through exigent circumstances. She also advised the auditor that the facility is routinely staffed with at least six staff per each day shift (7a to 11p) and at least five (5) staff for the overnight shift (11p-7a). This was also confirmed by the auditor through observations made during the onsite visit of at least six staff on the 7-3 shift and at least 6 staff on the 3-11 and upon review of the agency's staff schedule for July.

Additionally, the Facility provided the Auditor the original Staffing Plan Memorandum and Assessment from August 1st, 2016. The Memorandum states that over the course of several months in 2016, the Chief JPO (Director of JCJPD), Casework Manager, and Detention Superintendent/PREA Coordinator met weekly to enhance the MRJJC Staffing Plan in efforts to ensure that all PREA components have been included in the plan. The following were considered in the development process:
- Prevailing staffing patterns;
- The Department's deployment of video monitoring systems and other monitoring technologies; and
- The resources the Department has available to commit to ensure adherence to the staffing plan.
Policy 3.8, which includes the staffing plan, was approved by the Jefferson County Juvenile Board on June 16, 2016 (as per the Memorandum, which was signed by the Chief).

During the auditor's facility inspection, he was able to identify cameras in each of the housing areas, each Dorm and hallway, intake, dayrooms, library, cafeteria, counseling rooms, and recreation areas. Furthermore, the auditor was provided access to the agency's Central Control room, supervisor's office, and Superintendent's office; in which all rooms/offices were confirmed to have video monitoring capabilities. The Central Control room has six (6) monitors (including one large 56" monitor), which provides the control room officer the capability to observe multiple camera views at one time. The supervisor's and Superintendent's offices include two monitors that allow the applicable staff member to view surveillance video while still being able to use the other monitor for computer work.

Additionally, the auditor interviewed the agency's Superintendent, and he confirmed that MRJJC regularly develops a staffing plan and that the plan is reviewed at least once per year

with the Chief of the agency. It was explained by the Superintendent that he continually evaluates the resident population (to identify an influx of residents or staff shortages), staff schedules (reviews daily), and staff attrition and is in constant talks with the Chief in order to ensure adequate staffing levels are maintained at all times (1:8/1:16). He also provided an example of how the agency exceeds the minimally required staffing ratios, by explained that during the overnight shift the night before, the facility utilized four (4) staff to supervise a population of 13 residents (a ratio of 1 staff for every approx. 3 residents- 1:3). This was also verified by the auditor by reviewing the agency's JSO Schedule for July 2019 that showed the four staff working the overnight the Superintendent reference to (with the Resident Roster reflected 13 residents in detention). Furthermore, it should be noted that in the previous 5 years (2014-2018), the JCJPD 2018 Annual Report reflects that the average population for each year never exceeded 25 residents, and the lowest average days reported was for the year of 2018, with 17. The Superintendent also described:

- the agency's on-call system of always having two supervisors on-call in case of emergencies;
- how staff can be called in, if needed (and they have available a pool of part-time certified JSOs and dually certified JSO/JPO staff members that can be called in, if necesary);
- how when assessing adequate staff levels and the need for video monitoring that the eleven requirements of this PREA provision are included;
- the staffing plan review process, which includes (but is not limited to): classification of residents, work assignments/locations for staff (putting staff in locations where they are most effective in supervising residents), the agency's video monitoring system (which does not count for supervision), and assessing for vulnerable areas of the facility and ensuring sexual safety, reviewing the plan with the Chief of the agency at least annually, and posting the plan on the agency's website;
- how staff are trained on ensuring proper resident supervision ratios are maintained at all times;
- how the supervisors work to ensure the facility is adequately staffed at all times and how they ensure staff are providing direct line of sight of the residents they are supervising; and
- how all certified JSOs are essential personnel county employees, who must stay at their assigned work assignment and not abandon their shift or post until relieved by an incoming staff member or they receive approval or notification by a supervisor.

Additionally, the Casework Manager explained to the Auditor that even though the average population was only 17 for 2018 (as verified in the JCJPD 2018 Annual Report), the Facility has maintained staffing levels to adequately supervise up to 40 residents. She clarified to the Auditor that the staffing levels are sustained to supervise 40 residents in order to ensure at all times the Facility is staffed for any exigent circumstance that may arise (i.e., a hurricane or other type of unforeseen emergency).

The auditor was able to verify the agency completed a Staffing Plan Assessment on May 21st, 2019 and August 1, 2016; and the assessment was reviewed and signed by the Chief, Casework Manager, and the Superintendent. The auditor also was provided an "Essential Personnel" form that was reported by Casework Manager to be signed by all certified employees that work in the detention center (all JSO staff). This was verified by the auditor upon reviewing eight (8) employee personnel files, which included the Essential Personnel form signed and dated by all eight staff members. This form outlines that the Jefferson County Commissioner's Court has designated JSOs as "essential personnel" and authorizes their

work during an emergency or crisis situation such as hurricane evacuations. The form also requires staff to document and provide to the Superintendent a cellular phone number, home phone number, and/or any other number at which they may be reached prior to, during and/or after an emergency.

Lastly, the auditor completed a facility inspection with the Detention Superintendent/PC on the first day of the onsite, and during this time, the auditor was escorted throughout the entirety of the secure facility. Upon walking into the main dayroom area of the secure facility, the auditor observed one male resident talking with two volunteers (Volunteers of the Foster Grandparent Program), with a male staff member in the dayroom supervising the resident. This area also included cameras that were focused to cover all areas of the dayroom. The next area the auditor observed was Dorm 1 that included three male resident PODs (housing units), with eight (8) resident rooms per POD. The PODs in Dorm 1 are designated as: Apod, Bpod, and Cpod (with each Dorm hallway and each POD having two surveillance cameras). Each POD had a secure door to enter and exit the POD that staff had to use a key to open. The Superintendent opened a locked door from the Dorm #1 hallway that led into Apod. Apod did not have any residents in the POD during the facility inspection, and the Superintendent informed the auditor that Apod was not being used for housing at the moment. This POD had two cameras and the entry and exit doors were securely locked. The next POD inspected and observed by the auditor was Bpod, with two male residents on the POD sitting in the dayroom playing a game and one male staff member supervising. Bpod was accessed through a secure door in between Apod and Bpod, and Bpod included two surveillance cameras. Lastly, the auditor walked with the Superintendent through a locked door from Bpod into Cpod, which had four (4) male residents sitting in the POD's dayroom watching TV and two male staff members supervising. Cpod also had two cameras. This completed the inspection of Dorm 1, and the auditor and the Superintendent then walked to Dorm 2. Dorm 2 includes: Dpod, Epod, and Fpod; with Fpod being used for housing the female residents, Epod being used to program the same female residents, and Dpod closed/empty. The Dorm #2 hallway and each POD included two surveillance cameras per secure area, and each POD was accessed through a locked door, as explained for Dorm #1. The auditor observed four (4) female residents sitting at a table in the Epod dayroom, drawing coloring pages; with two female staff supervising the residents. In sum, all the areas observed by the auditor in which residents where programming were being supervised by a staff member of the same gender, and at no time did the auditor observe the facility fall below the required staffing ratio of 1:8 during waking hours/programming.

115.313 (b):
Agency Policy 3.8 on page 7 describes that the department shall comply with the staffing plan except during limited and discrete exigent circumstances, and shall fully document deviations from the plan during such circumstances. The auditor asked the Superintendent (PC) if any such deviations to the staffing plan have ever occurred, and he explained that, as far as he is aware, in the twenty plus years of working in the MRJJC, they have never deviated from the agency's staffing plan, regardless of any temporary or unforeseen type situations that have occurred. Additionally, the PC provided the Auditor with two examples of how an exigent circumstance occurred during Hurricane Ike in 2008 and Hurricane Harvey in 2017, and how the Agency leadership ensured adequate staffing levels throughout each event. He advised that all certified JSO staff are "essential personnel" that are required to be called in or remain at work until further notice in cases of emergencies and exigent circumstances. The Facility

provided the Auditor the “Essential Personnel Acknowledgement Forms” from each personnel file reviewed (9 JSO files), and each form was signed and dated by the applicable staff member. The PC explained the he was working at the MRJJC during each Hurricane, and through each event, the Facility remained fully staffed and at no time was the staffing plan or the staff to resident ratio deviated. The Superintendent explained further that if the facility is ever in a situation in which the staffing plan could not be adhered to, then an incident report would be completed, the situation would be immediately reviewed with the Chief, and a solution would be implemented to rectify the problem or issue. The agency’s documentation in the PAQ also reflects that the agency has not deviated from their staffing plan, and the auditor verified the agency’s practice of providing adequate staffing ratios by reviewing the staff schedule for the entire month of July. The JSO Schedule for July indicates that the facility scheduled at least four staff members (usually 5) on each of the two day shifts (7a-11p) and at least three (usually 4) on the overnight shift (11p-7a), while the facility population never peeked above 18 residents (per the PREA Coordinator’s information provided).

115.313 (c):
Agency Policy 3.8 on page 5 prescribes the PREA mandatory certified JSO staff to resident ratios, and are as follows:

- Facility Wide Ratio- No less than 1:8 ratio of certified staff (JSOs) to youth during program hours (waking hours) and 1:16 ratio of certified staff (JSOs) to youth during non-program hours (sleeping hours); and
- Supervision Ratio- No less than 1:8 ratio of certified staff (JSOs) to youth during program hours and 1:16 during non-program hours.

Additionally, Policy 9.3 outlines the agency’s ability to ensure juveniles are never left unattended in any area inside or outside the facility. This Policy explains that intensive staff supervision is intended to reduce reliance on security hardware (surveillance cameras) and to promote a positive relationship between staff and juveniles as the primary means of control. 9.3 also describes the agency’s requirement of having at least one JSO maintaining visual contact with each juvenile, and that staff should not leave their area of responsibility without first informing the Control Center. JSOs are required, per this Policy, to conduct periodic head counts to ensure the earliest possible detection of an absent juvenile, and head counts are also required when transporting residents to one area of the facility to another. Furthermore, this Policy requires that juveniles are never to be left unattended while in a common activity area, and that during program hours, juveniles shall be in constant physical presence of a JSO, unless the juveniles are placed in their rooms, whereas, JSOs will then complete room observation checks at staggered intervals not to exceed 15 minutes. Audio and video monitors are described to not be substituted for direct supervision of juveniles. The Policy explains that juveniles are never to be allowed to enter the janitor’s closet, the kitchen, the property room, or the laundry room. Lastly, 9.3 states that there shall be a minimum of four (4) staff members on duty during waking hours and three (3) during sleeping hours- providing a minimum ratio with the average population of 17 (in 2018) of at least 1:8 and 1:16, respectfully. This Policy describes that if all possible, a JSO of one gender shall not be the sole supervisor of a juvenile of the opposite gender. This was also verified by the auditor when he was onsite, with only male staff supervising the male residents and only female staff supervising the female residents.

It should be noted that Texas Administrative Code Chapter §343.436 (Supervision Ratio) requires that juvenile facilities in Texas operate a JSO-to-resident ratio of no less than:

- one juvenile supervision officer to every 12 residents during program hours; and
- one juvenile supervision officer to every 24 residents during non-program hours.

In order for the MRJJC to comply with this PREA provision, the facility exceeds the minimum requires of JSO-to-resident ratio of TAC and adheres to the PREA required ratios of 1:8 and 1:16.

Additionally, the PAQ answer to Standard §115.313 (c)- #2 through #5 submitted by the agency reflects that the agency maintains the required PREA ratios of 1:8 and 1:16 respectfully, and in the past 12 months, the facility has never deviated from those ratios. As described in subsection (b) of this provision, if the agency would ever deviate from the required minimum staffing ratios, this would be documented on an incident report, immediately addressed by the Superintendent and Chief, and a solution would implemented to correct the problem.

As a means to verify the agency's compliance with this PREA provision, the auditor completed a facility inspection with the Detention Superintendent/PC on the first day of the onsite, and during this time, the auditor was escorted throughout the entirety of the secure facility. Upon walking into the main dayroom area of the secure facility, the auditor observed one male resident talking with two volunteers (Volunteers of the Foster Grandparent Program), with a male staff member in the dayroom supervising the resident. The next area the auditor observed was Dorm 1 that includes three male resident PODs (housing units), with eight (8) resident rooms per POD. The PODs in Dorm 1 are designated as: Apod, Bpod, and Cpod. Apod did not have any residents in the POD during the facility inspection, and the Superintendent informed the auditor that Apod was not being used for housing at the moment. The next POD inspected and observed by the auditor was Bpod, with two male residents on the POD sitting in the dayroom playing a game and one male staff member supervising. Lastly, the auditor walked with the Superintendent into Cpod, which had four (4) male residents sitting in the POD's dayroom watching TV and two male staff members supervising. This completed the inspection of Dorm 1, and the auditor and the Superintendent then walked to Dorm 2. Dorm 2 includes: Dpod, Epod, and Fpod; with Fpod being used for housing the female residents, Epod being used to program the same female residents, and Dpod closed/empty. The auditor observed four (4) female residents sitting at a table in the Epod dayroom, drawing coloring pages; with two female staff supervising the residents. In sum, all the areas observed by the auditor in which residents where programming were being supervised by a staff member of the same gender, and at no time did the auditor observe the facility fall below the required staffing ratio of 1:8 during waking hours/programming.

Furthermore, the Facility Superintendent/PC informed the Auditor during his interview that the agency has never fallen below the PREA required staffing ratios (1:8/1:16) during his tenure and that TJJD (TAC) requires the agency to adhere to a 1:12 and 1:24 staff to resident ratio (in which the Facility exceeds the TAC requirement in order to follow the PREA requirements). Additionally, the PC explained that he ensures the required PREA ratios are maintained at all times by following the MRJJC's Staffing Plan Policy (3.8), constantly assessing staffing levels (taking into consideration attrition & reviewing the staffing schedule daily), resident population

(influxes/patterns), and remaining in constant communication staff and his management team.

Additionally, the agency's Superintendent explained that he continually evaluates the resident population (to identify an influx of residents or staff shortages), staff schedules (reviews daily), and staff attrition and is in constant talks with the Chief in order to ensure adequate staffing levels are maintained at all times (1:8/1:16). He also provided an example of how the agency exceeds the minimally required staffing ratios, by explained that during the overnight shift the night before, the facility utilized four (4) staff to supervise a population of 13 residents (a ratio of 1 staff for every approx. 3 residents- 1:3). This was also verified by the auditor by reviewing the agency's JSO Schedule for July 2019. The Superintendent also described:

- the agency's on-call system of always having two supervisors on-call in case of emergencies;
- how staff can be called in, if needed (and they have available a pool of part-time certified JSOs and dually certified JSO/JPO staff members that can be called in, if necesary);
- how when assessing adequate staff levels and the need for video monitoring that the eleven requirements of this PREA provision are included;
- the staffing plan review process, which includes (but is not limited to): classification of residents, work assignments/locations for staff (putting staff in locations where they are most effective in supervising residents), the agency's video monitoring system (which does not count for supervision), and assessing for vulnerable areas of the facility and ensuring sexual safety, reviewing the plan with the Chief of the agency at least annually, and posting the plan on the agency's website;
- how staff are trained on ensuring proper resident supervision ratios are maintained at all times;
- how the supervisors work to ensure the facility is adequately staffed at all times and how they ensure staff are providing direct line of sight of the residents they are supervising; and
- how all certified JSOs are essential personnel county employees, who must stay at their assigned work assignment and not abandon their shift or post until relieved by an incoming staff member or they receive approval or notification by a supervisor.

115.313 (d):
The agency provided the auditor with Policy 3.8 that includes on page 7 the agency's procedures for conducting an assessment of the Safe Housing Staffing Plan (Policy 3.8) whenever necessary, but no less frequently than once each year. The assessment is stated to determine and document whether adjustments are needed to the requirements of this provision (a-d).

Additionally, the agency provided the auditor with their Staffing Plan Assessments from May 21, 2019 and August 1st, 2016. Each assessment provides a detailed explanation of the following:

- Operating Capacity (48 in 2019)
- Current Capacity (27 in 2019)
- A Staffing Plan Review (number of staff assigned to each shift, 5 on the day shift (7a-11p) and 4 on the overnight shift (11p-7a)
- Current Staffing Ratio (1:8/1:16)
- A Review of Facility Monitoring System (89 total cameras with locations)
- A note explaining where residents are not allowed access, where cameras are positioned to

monitor these areas, and where audio speakers are located to supplement staff direct supervision and cameras.
- Other Monitoring Technologies in Use
- Any findings of inadequacy from judicial, federal investigative agency, internal or external oversight body.
- All components of the facility's physical plan, including blind spot areas or locations where staff or residents may be isolated.
- Staffing Plan Considerations (juvenile populations, numbers and placements of staff supervising juveniles; any applicable state, local, or federal laws, regulations, or standards; and the prevalence of substantiated and unsubstantiated incidents of sexual abuse.
- A review of facility resources available and committed to ensure adherence to staffing plan (part-time staff availability and dually certified JSO/JPO staff members that can be called in if needed.
- A review of facility policy to ensure intermediate to higher level supervisors complete unannounced rounds.
- Changes of Facility Layout- if applicable.
- Approval of review by the PREA Coordinator/Superintendent, Casework Manager, and Chief Juvenile Probation Officer.

It should be noted that the agency reported to the auditor that they did not complete a formalized Staffing Plan Assessment in 2017 or 2018; although during those years, the Superintended (who is the PREA Coordinator) and the Chief of the agency acknowledged in their interviews that the staffing plan (Policy 3.8)- as related to staff patterns, monitoring technology, and the allocation of agency resources to commit to the staffing plan to ensure compliance- was continuously assessed and evaluated by the management team on a daily basis. Furthermore, this was verified by the auditor by analyzing the agency's Staffing Plan Policy 3.8, two Staffing Assessment Reports from 2016 and 2019, reviewing 8 randomly selected personnel files that included 8 signed Essential Personnel forms (ensuring staff understand and agree to work during emergency situations), reviewing data related to average daily populations of the facility and comparing this data to staff schedules for the entire month of July 2019, and through interviewing the Superintendent and Chief of the agency (as explained throughout this standard explanation- each providing testimony that the staffing plan was never deviated and all elements of the staffing plan were assessed on a daily basis since the last PREA audit). Due to the staffing plan reviews not being formally completed in 2017 and 2018, the Auditor determined that the Agency is not in compliance with this particular PREA provision {§115.313 (d)}; therefore, prompting corrective action. During the pre-onsite audit phase, the Casework Manager provided to the auditor an improvement plan to address the non-compliance with this provision to ensure future annual staffing plan assessments will be completed going forward. This plan involves the Superintendent being responsible for updating the agency's Annual Inspection List and emailing it to all Detention Supervisors, the Casework Manager, and the Chief. The Casework Manager confirmed with the auditor that the Superintendent has already updated the annual inspection list with the Staffing Plan Assessment, PREA MOUs, and annual review of SA/SH incidents, and this document was provided to the auditor through an email attachment after the onsite visit.

Ultimately, the auditor determined that in the past 12 months the agency has complied with and institutionalized the PREA staffing plan requirements of §115.313 (d) of assessing, determining, and documenting whether adjustments are needed to the staffing plan, prevailing

staffing patterns, the facility's deployment of video monitoring systems and other technologies, and the resources the facility has available to commit to ensure adherence to the staffing plan. The Agency has institutionalized Policy 3.8 (that includes the original staffing plan) and provided the Auditor with their Staffing Plan Assessment from May 21st, 2019, and each document fulfils the requirements of this PREA Standard provision. With the corrective action plan already fully implemented (as determined by the auditor through conversations with the Chief, Casework Manager, and Superintendent and the documentation of the annual list), future staffing plan assessments and other annual reviews and inspections should not be missed.

115.313 (e):
Agency Policy 3.8 on page 7 describes that unpredicted, unannounced rounds are performed during all shifts throughout the areas of the facility and are performed in person by the Detention Superintendent and the two Detention Casework Supervisors at least weekly at random unscheduled and unpredictable times and dates during their rotation. Also, this policy states that the department shall prohibit staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational function of the facility. Casework Supervisors, per the agency's organizational chart, are considered intermediate to higher-level staff and report directly to the Detention Superintendent- who reports directly to the Casework Manager. The auditor verified this through an analysis of the agency's PREA Unannounced Rounds forms that were completed for the month of May 2018 and uploaded in the PAQ, which included three sets of unannounced rounds documented for each of the three shifts (7-3, 3-11, & 11-7). Each of the unannounced rounds documented adequately demonstrated how each round was conducted on random days and at random times (i.e., the days of the unannounced included: Sundays, Mondays, Wednesdays, Thursdays, and Saturdays; and the times included: the beginning, middle, and end of each shift). Additionally, the agency provided the auditor (via the PAQ), their PREA Verification of Monthly Unannounced Round Reports for the past 12 months. These monthly reports are produced by the Casework Manager, and the data supplied for the monthly reports are transferred from the completed Unannounced Round forms that are turned into her upon completion (per the Casework Manager). The auditor verified that each report documented an average of six unannounced rounds on all three shifts for the past 12 months.

Furthermore, the auditor also reviewed surveillance video while onsite of unannounced rounds being conducted by each of the two Casework Supervisors and the Superintendent in the month of July of 2019 for each of the three shift. One of the Casework Supervisors allowed the auditor to view each unannounced round made on the 7-3 shift, 3-11 shift, and 11-7 shift, and the auditor was able to clearly observe each supervisor walking through each of the housing areas, dorms and other areas of the facility.

In addition, the auditor also interviewed the two Casework Supervisors who conduct the unannounced rounds, and each of the supervisors provided the following supporting information:

- Casework Supervisor #1: She stated that the unannounced supervisory rounds are either conducted by herself, the other Casework Supervisor, or the Superintendent. This supervisor also stated that each unannounced round being completed is documented on a form that lists

each room inspected, all storage areas, intake, dorms, and where the person began the round and where he/she finished (entry & exit points); and this form is then turned into the Casework Manager. Additionally, this supervisor provided information related to how she ensures staff are not made aware of the rounds being conducted by not announcing herself over the radio (*only making an announcement when going on opposite gender POD- but generic statement of “female on the POD/Dorm”), being as quiet as possible, and avoiding radio traffic. She verified in her interview that the unannounced rounds are conducted on each of the three shifts at a minimum of once per week.
- Casework Supervisor #2: He stated that he does conduct unannounced rounds that are documented on the Unannounced Rounds form, and that this form lists out every single room in the facility. The supervisor stated that he turns in the completed forms to the Casework Manager upon completion, and that the Casework Manager documents all rounds in a monthly log/report. He explained the process of ensuring staff are not alerting to the rounds being conducted by randomly showing up in the building unannounced on their off days and then flexing the time on a later date. At times, he explained to the auditor, the PREA Coordinator or himself may take a radio home to ensure staff are not making announcements that alert staff that the rounds are going to be conducted, and the staff are advised during PREA training that it is prohibited to alert staff in such cases.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required

115.315 Limits to cross-gender viewing and searches

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.315

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 9.8 (Searches of Locations and Juveniles) / Last updated: 06/16/2016
- Agency Policy 14.3 (Bathing & Hair Care Facilities for Juveniles) / Last updated: 06/02/2014
- Minnie Rogers Juvenile Justice Center (MRJJC) Monthly Detention Training, to include: PREA updates, PREA Orientation with Juveniles, and Cross Gender Pat Downs & Searches on Transgender and Intersex Juveniles.
- PREA Training Sign-in Sheets for Training Verification
- Staff Roster (used to cross-reference Training Verifications)
- Texas Administrative Code 343.260 (Resident Searches)

Interviews:

- Casework Manager
- 12 Randomly Selected Staff
- 11 Randomly Selected Residents

Site Review Observations:

During the onsite audit, the auditor observed that Apod, Cpod, Dpod, and Fpod are the only PODs with shower areas, and Bpod and Epod are PODs that can house residents but do not have showers. The shower areas on each applicable POD are individual showers, and the auditor verified that residents are able to shower without being viewed on camera by reviewing male shower times on the agency's surveillance camera system from the previous day. The auditor also was provided access to the agency's intake processing area, which are two rooms with an office area and shower area for incoming juveniles to shower and change. All areas, except the shower areas, of both intake processing rooms are continuously monitored by surveillance cameras, as verified by the auditor during the facility inspection and through reviewing camera surveillance video while inspecting the facilities central control room.

Explanation of determination:

115.315 (a):
The agency indicated in the PAQ that they do not conduct cross-gender strip or cross-gender visual body cavity searches of residents and reported they have not had any such searches in the past 12 months. The auditor was also able to verify this prohibition in agency Policy 9.8, which states on page 2, "a staff member of the same gender shall conduct a strip search as the juvenile being searched, except in exigent circumstances or when performed by medical practitioners." Policy 9.8 on page 2 explains that all exigent circumstances must be approved by the Chief Probation Officer or designee and documented. Additionally, Policy 3.8 on page 3

states, “an anal or genital body cavity search must be authorized by the Chief Probation Officer or designee and will be done only when there is probable cause to believe that a juvenile is concealing contraband. Only a physician or physician assistant that is the same gender of the juvenile may perform a body cavity search, and all body cavity searches shall be conducted in the medical room or an office and documented by the Chief Probation officer or designee.”

It should be noted that TAC Chapter 343.260 (b) (3) (C) also prohibits the facility from conducting cross-gender strip searches and states: “a strip search shall be conducted by a staff member of the same gender as the resident being searched.” Additionally, TAC 343.260 (b) (4) (A) states, “an anal or genital body cavity search shall be conducted only by a physician or physician assistant, and the physician or physician assistant shall be of the same gender as the resident, if available.”

During the onsite audit, the auditor asked 12 randomly selected Juvenile Supervision Officers (JSOs) if they had ever conducted a cross-gender search of any kind (including strip and visual body cavity searches) while working for the MRJJC, and all 12 staff stated they had not and that this practice is prohibited. Additionally, the auditor also asked 11 randomly selected residents if a staff member of the opposite gender had ever conducted a search on them while they have been in the facility, and each resident stated this has never occurred.

115.315 (b):
Agency Policy 9.8 on page 3 states that the department shall not conduct cross-gender pat-down searches except in exigent circumstances, which must be approved by the Chief Probation Officer and a justification of the search must be documented. The agency indicated in the PAQ that they had zero incidents involving a cross-gender pat-search of a resident in the past 12 months.

Additionally, TAC 343.260 (b) (1) prohibits the agency from conducting cross-gender pat-searches, and the standard explicitly indicates that residents shall only be subjected to a pat-down search that is conducted by same-gender staff, as necessary for facility safety and security.

During the onsite audit, the auditor asked 11 randomly selected residents if a staff member of the opposite gender had ever conducted a pat-search on them while they have been in the facility, and each resident stated this has never occurred. The auditor also asked 12 randomly selected JSOs if they had ever conducted a cross-gender pat-down search of a resident while working for the MRJJC, and all 12 staff stated they had not and that this practice is prohibited, except in exigent circumstances. The auditor probed each staff member to ensure all the randomly selected staff understood what an exigent circumstance was and the procedures in such a case for conducting cross-gender pat-down searches, and each staff member clearly articulated their knowledge of how an exigent circumstance is a temporary and unforeseen emergency (examples provided by staff: riot situation and weather related emergencies) and that this would require Chief approval before being conducted. Each staff member advised the auditor that they were trained on the agency’s procedures related to a cross-gender pat-down search during the most recent PREA training in May of 2019, and the auditor was able to verify that each staff member interviewed did attend the training in May through cross-referencing the training sign-in sheets provided in the PAQ. The Casework Manager provided

the auditor with the training curriculum that is covered when staff are trained on how to conduct a search of a resident in the facility, and this material includes all the requirements of PREA Standard 115.315.

While onsite, the auditor made a recommendation to the agency's management team to enhance their training as it relates to cross-gender pat-down searches and searches of transgender and intersex residents; this enhancement included the recommendation to add the following resource that is available on the PREA Resource Center website:

- The Moss Group Introductory and Guidance Videos on Cross-Gender and Transgender Pat Searches (also includes a facilitator's guide and PowerPoint slides).

The Casework Manager advised the auditor after the onsite that she will definitely work to incorporate the Moss Group training material in all upcoming PREA Trainings related to pat-searches. Furthermore, after the onsite, the Casework Manager stated in an email follow-up that the Agency will be utilizing the Moss Group video at their next training.

115.315 (c):
Agency Policy 9.8 on pages 2-3 state that cross-gender searches of any kind (pat-down, strip, & visual body cavity searches) shall be approved by the Chief and justification would then be documented for each incident. The agency indicated in the PAQ that they have not experienced a cross-gender search incident of any kind in the past 12 months; and, therefore, the auditor was not provided documentation of such an incident. Although, the agency did report to the auditor that if an exigent circumstance were to occur and the Chief approves for a cross-gender search, the justification would be thoroughly documented in a report (such as an incident report).

115.315 (d):
Agency Policy 14.3 on page 2 outlines procedures to enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breast, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks. This policy also describes the requirement of staff of the opposite gender to make an announcement when entering a resident housing unit.

During the onsite audit, the auditor observed that Apod, Cpod, Dpod, and Fpod are the only PODs with shower areas, and Bpod and Epod are PODs that can house residents but do not have showers. The shower areas on each applicable POD are individual showers, and the auditor verified that residents are able to shower without being viewed on camera by reviewing male shower times on the agency's surveillance camera system from the previous day. The auditor also was provided access to the agency's intake processing area, which are two rooms with an office area and shower area for incoming juveniles to shower and change. All areas, except the shower areas, of both intake processing rooms are continuously monitored by surveillance cameras, as verified by the auditor during the facility inspection and through reviewing camera surveillance video while inspecting the facilities central control room.

Furthermore, the auditor interviewed 12 randomly selected staff during the onsite, and each staff member advised that all residents are able to dress, shower, and use the toilet without being viewed by staff of the opposite gender. One female staff member provided additional

information to the auditor that all female residents are instructed to be fully dressed before leaving the shower area and all residents shower one at a time, and a male staff member advised the auditor during his interview that opposite gender staff never enter the POD during shower times.

Each staff member interviewed also advised that an announcement is made every time a staff member enters a POD with residents of the opposite gender. The most prevalent examples of how an announcement is made by staff entering an opposite gender POD were: “male on the POD” and “female on the POD.” Additionally, since the facility includes two Dorms that include three PODs per Dorm, all staff interviewed also explained to the auditor that each time they enter the Dorm area that includes a POD of opposite gender residents, staff make an announcement of: “male/female on the Dorm.” This is in addition to the announcement that is made before staff enter the actual POD that houses the residents. The practice of staff making the two announcements was confirmed by the auditor during the facility inspection, and throughout his time in the facility during the onsite.

Additionally, all 11 randomly selected residents interviewed by the auditor advised that they are able to dress, shower, and use the toilet without staff of the opposite gender viewing them. The same 11 residents also confirmed that the announcements are routinely made by staff of the opposite gender before they enter the POD and Dorm areas, and the announcements are either “male/female on the POD” or “male/female on the Dorm.”

115.315 (e):
Agency Policy 9.8 on page 2 outlines the requirements of this provision and explicitly states that searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident’s genital status is prohibited. The agency indicated in the PAQ that no such searches occurred in the past 12 months.

During the onsite audit, the Superintendent/PC advised the auditor that the facility currently did not have a resident who identified as transgender or intersex, and throughout the auditor’s observations and interactions with the resident population from the onsite visit, the auditor did not observe that a resident identified as transgender or intersex. Additionally, the auditor reviewed 9 resident detention files, and analyzed each resident’s Behavioral Screen to check for any residents who identified as transgender or intersex. Upon review, all 9 resident Behavioral Screening’s indicated that all 9 residents identified as straight or heterosexual when screened in intake or during their applicable periodic reassessment and none of the residents identified as transgender or intersex (pursuant to 115.341).

The testimony from each randomly selected staff member interviewed by the auditor verifies that the practice of searching or physically examining a transgender or intersex resident for the sole purpose of determining their genital status is strictly prohibited, and each staff member stated that such a search has never occurred while they have worked for the agency.

115.315 (f):
The agency provided the auditor with PREA training verifications for each of the 27 certified JSOs who currently work in the facility (27 JSO staff members names were provided on a staff roster), and each of the 12 randomly selected staff members confirmed in their interview that they have received training related to the PREA requirements of this standard. The staff

members interviewed described to the auditor that they have never experienced a transgender or intersex resident in the detention center, and how if a resident who identifies as transgender or intersex is admitted into detention, the resident's case would be handled on a case-by-case basis. It was explained by staff that a Casework Supervisor would be notified and the decision on how to proceed with the pat-search would travel up the chain of command, up to the Director of the Department. The training described by staff in their interviews included ensuring the transgender or intersex resident is pat-searched with the staff member who he/she feels most comfortable with, and each staff explained that they received pat-search training that included to conduct the search in a professional and respectful manner and covering the agency's search policy.

Additionally, the Casework Manager provided the auditor with the training curriculum that is covered when staff are trained on how to conduct a search of a transgender or intersex resident that is admitted into the facility, which included a review of the agency's Policy 9.8 (Security and Control). This Policy includes the following procedures:
- Inform the juvenile quietly and simply what is about to take place.
- The juvenile should not be touched any more than is necessary to conduct a comprehensive search which means authorized staff conducting searches shall refrain from excessively forceful touching, prodding, or probing that may cause pain or injury and shall also refrain from search techniques that may resemble fondling, especially in the area of the resident's breasts, genitalia, and buttocks.
- Staff shall conduct themselves in a professional manner and refrain from making inappropriate remarks or comments about the search process, the juvenile being searched, or the juvenile's body or physical appearance.
- Staff members' communications during the each shall be limited to the verbal instructions and request necessary to conduct an effective and efficient search and to provide for juvenile, staff, and facility safety.
- Every effort shall be made to prevent embarrassment or humiliation of the resident when conducting searches.
- The Department shall not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status. If the resident's genital status is unknown, it may be determined 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.

While onsite, the auditor made a recommendation to the agency's management team to enhance their training as it relates to cross-gender pat-down searches and searches of transgender and intersex residents; this enhancement included the recommendation to add the following resource that is available on the PREA Resource Center website:

- The Moss Group Introductory and Guidance Videos on Cross-Gender and Transgender Pat Searches (also includes a facilitator's guide and PowerPoint slides).

The Casework Manager advised the auditor after the onsite that she will definitely work to incorporate the Moss Group training material in all upcoming PREA Trainings related to pat-searches.

Conclusion:

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.316 Residents with disabilities and residents who are limited English proficient

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.316

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 12.5 (Sexual Abuse & Mistreatment) / Last updated: 09/02/2016
- Email communications from Abshire Interpreting and the Agency (from 2016)
- Memo from the PC explaining that the agency has not had to use a resident interpreter in the past 12 months.
- Resident Handbook (English and Spanish)
- Resident PREA Orientation Video (English and Spanish)

Interviews:

- Agency Head
- Random Sample of Staff

Site Review Observations:

During the onsite audit, the auditor did not observe or communicate with a resident who had a disability or who was limited English proficient. Out of the eleven residents interviewed, not one reported to the auditor of having a disability and all spoke fluent English. The PC also advised the auditor that the facility did not have a resident who had a known disability or who was limited English proficient while the auditor was onsite. Additionally, the PC provided the auditor a memo in the OAS that explains that the MRJJC has not utilized any resident interpreters during the past 12 months prior to the audit. The auditor also reviewed the PREA Education video that the facility provides each resident, and the video was available in English and Spanish versions. The agency's Resident Handbook was also provided to the auditor, and the facility had an English and Spanish version available.

Explanation of determination:

115.316 (a) & (b):
Policy 12.5 on page four (4) explains that juveniles with disabilities (including juveniles who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities) shall have 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. Additionally, this Policy also states that the department shall take reasonable steps to ensure meaningful access to all aspects of the department's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to juveniles who are limited English proficient, including steps to provide interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using an necessary specialized vocabulary. The auditor also reviewed the PREA Education video that the facility provides each resident, and

the video was available in English and Spanish versions. The agency's Resident Handbook was also provided to the auditor, and the facility had an English and Spanish version available.

As stated above in the description of the onsite, the facility did not have a resident in the facility during the time the auditor was onsite that was known to have a disability or limited English proficient.
In order to verify that the interpreting services that were available for residents at the MRJJC were in compliance with this standard provision, the auditor reached out to the owner of the interpreting company that the MRJJC contracts with. The owner advised the auditor that the interpreting services that her company provides are available to residents of the MRJJC, and that such services include, but are not limited to:

- Sign-language (a Court certified interpreter is available).
- Deaf, hard of hearing, and blind interpreting (have staff that specialize in this service and all are certified either through the State of Texas and/or nationally certified.
- Have interpreters that specialized in communicating with juveniles with mental and physical disabilities.

The auditor interviewed the Chief of the Department who advised that the agency has established procedures to provide residents with disabilities and residents who are limited English proficient 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. The Chief also explained that the agency employees two bilingual staff members (both speak fluent English and Spanish), one works in the Detention Center as a JSO and the other staff member is a JPO in casework, that are available to translate if necessary.

Additionally, it was also described through informal conversations with agency's Mental Health Provider (MHP) and the PC that the agency can utilize the MHP to help with any communication problems that a resident with a disability may encounter during his/her stay in the detention center. The MHP is a fulltime employee for the MRJJC, and she is also available after hours (as explained by the Casework Manager and MHP).

115.316 (c):
Per Policy 12.5 on page 4, the department shall not rely on juvenile interpreters, juvenile readers, or other types of juvenile assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the juvenile's safety, the performance of first-responder duties, or the investigation of the juvenile's allegations. Additionally, the PC provided to the auditor a signed document that states the MRJJC has not utilized any resident interpreters during this monitoring period (the past 12 months).

Additionally, 100% of the 12 random staff interviewed by the auditor described that resident interpreters are not used by the agency and that there are two staff available that can translate Spanish if necessary. The staff members interviewed were able to explain that the only time a resident interpreter would be used would be if it was an emergency type situation- a situation in which a delay would compromise resident safety. Furthermore, staff were able to describe that an interpreter service is available to a resident on an as needed basis.

Abshire Interpreting is the company the agency would utilize if needed for interpreting

services, and the auditor interviewed an affiliate from Abshire who explained that the interpreting services are available 24/7 to the agency.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.317 Hiring and promotion decisions

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.317

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 3.10 (Background Checks for Employees, Volunteers, Vendors, and Contractors) / Last updated: 06/02/2014
- MRJJC form that includes the questions regarding past conduct pursuant to 115.317 (f)
- NCIC reports
- TCIC reports
- Texas Department of Public Safety (TxDPS) Website
- Federal Bureau of Investigation (FBI) Website
- Texas Administrative Code (TAC) Title 37
- Volunteer List (including 21 total volunteers names)
- Contractor List (including a list of names for 4 medical contractors and 12 teachers, for a total of 16 contractors)

Interviews:

- Administrative (Human Resource)
- Casework Manager

Site Review Observations:

During the onsite audit, the auditor reviewed staff personnel and training files with the assistance of the Casework Manager- who helped with identifying where certain applicable documents were located in each file. The Auditor used his randomly selected staff interview list of 10 staff to select 8 randomly selected employee files (out of a possible 27 current staff-30%) to review for PREA compliance as related to this PREA standard. Additionally, the auditor reviewed the criminal history checks, child abuse registry checks, and PREA training verification forms for the following contractors and volunteers (4 contractors out of 37 total, 11%) while onsite:

- One contracted Doctor
- Two contracted nurses
- One volunteers of the Grandparents Fostering Program

To recap the number of contractors and volunteers, it should be noted that the agency reported in the PAQ that they had a total of 51; although, after clarification from the PC and Casework Manager, it was discovered that the actual number of contractors and volunteers was 37. The agency provided a list of names for each contractor and volunteer that included 37 names and a short description of each contractor's role for the MRJJC. Below is a breakdown of the number of contractors and volunteers:

- 12 teachers with BISD;
- 4 medical contractors (2 Doctors & 2 nurses); and
- 21 volunteers.
- Totaling: 37

Explanation of determination:

115.317 (a):
Agency Policy 3.10 on page one (1) outlines the requirements of this provision, and states that the department shall not hire or promote anyone who may have contact with residents and shall not enlist the services of any contractor who may have contact with residents who have any of the disqualifications as prescribed in subsections (1-3) of this PREA provision. Additionally, Policy 3.10 explains that the agency shall 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 prior to employment or beginning of work within the facility. Additionally, Policy 3.10 explains the agency's procedures for asking all applicants and employees who may have contact with residents directly about previous misconduct, as required by this PREA Standard (f), in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. Policy 3.10 on page 2 also states that the department shall impose upon employees a continuing affirmative duty to disclose any such misconduct.

The auditor reviewed eight (8) randomly selected employee files, one (1) randomly selected volunteer file, and three (3) contractor files in order to ensure the agency has implemented the provisional requirements of this PREA standard in practice, and each file included a cleared TCIC, NCIC, and Child Abuse Registry Check (with the Department of Family Protective Services) and answers to questions regarding past conduct pursuant to 115.317 (f).

115.317 (b):
Agency Policy 3.10 on page one (1) explains that the department shall consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.

The Human Resource Administrator (HRA) advised the auditor during her interview that if she was made aware of a staff or intern, volunteer, or contractor who was involved in a sexual harassment incident, she would report this to the Chief of the Department. The HRA explained that the Chief would get with the Juvenile Judge and the decision would be made by the Judge and Chief.

The auditor was not made aware of any staff member, contractor, volunteer, or intern being involved in a sexual harassment incident that relates the requirements of this provision.

115.317 (c), (d), & (e):
Policy 3.10 on page one (1) describes the agency requirement of conducting a criminal history and background search (Texas Crime Information Center with Texas Department of Public Safety- TCIS & National Crime Information Center with the Federal Bureau of Investigation-NCIC) and a Fingerprint Applicant Services of Texas search (FAST) on all prospective

employees, volunteers, interns, vendors, and contractors. Additionally, Policy 3.10 explains that the department will consult any child abuse registry maintained by the State or locality in which the employee, volunteer, intern, contractor and vendor would work; and 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 prior to employment or beginning of work within the facility. The criminal background search will include finger printing and may also include a driver's record check. Additionally, Policy 3.10 explains the agency's procedures for asking all applicants and employees who may have contact with residents directly about previous misconduct, as required by this PREA Standard (f), in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. Additionally, Policy 3.10 on page 2 states that employees are subject to subsequent criminal history, background searches at the time of their Certification Renewal or at any time deemed appropriate by the administration of the department for due cause, and that the department shall impose upon employees a continuing affirmative duty to disclose any such misconduct.

The auditor reviewed eight (8) randomly selected employee files, one (1) randomly selected volunteer file, and three (3) contractor files in order to ensure the agency has implemented the provisional requirements of this PREA standard in practice, and each file included a cleared TCIC, NCIC, and Child Abuse Registry Check (with the Department of Family Protective Services) and answers to questions regarding past conduct pursuant to 115.317 (f). Out of the 8 staff personnel files reviewed; four (4) of the employees have worked for the MRJJC for ten (10) years or longer, one (1) had six (6) years' experience, one (1) had two (2) years' experience, and the remaining two (2) had less than 12 months experience. This provided the auditor with a representative sampling of staff who have worked for agency for a short and long period of time. All the staff files included their original criminal background records check (both NCIC and TCIC) and child abuse registry check that was dated before their hire date and applicable background checks at least every two years (during the JSO recertification process with TJJD).

The auditor interviewed the Human Resource Administrator (HRA) who explained that the facility performs criminal record background checks and considers pertinent civil or administrative adjudications for all newly hired employees and all contractors, volunteers, and interns who may have contact with residents and all employees, who may have contact with residents, who are being considered for promotions. Additionally, the HRA advised the auditor that before hiring new employees or contractors who may have contact with residents, she runs a child abuse registry check by the State or locality in which a potential employee/contractor would work. The HRA also explained that the agency is currently in the process of subscribing all their employees, volunteer, interns, and contractors from the FACT Clearinghouse to the FBI's Record of Arrest and Prosecutions Background- Rap Back. The FACT Clearinghouse was used by the agency prior to the Rap Back, and FACT is described as a repository of the DPS and the FBI fingerprint-based criminal history results. Per the TxDPS website, the FACT Clearinghouse allows an authorized entity access to a consolidated response of the DPS and FBI criminal history fingerprint results, including an electronic subscription and notification service for new arrest activity on subscribed persons. Only persons processed through Fingerprint Applicant Services of Texas (FAST) are eligible for FACT, and FAST is a service of the DPS that provides the electronic capture and submission

of fingerprints for a fingerprint background check. Per the FBI's website, with Rap Back, authorized government agencies will receive on-going status notifications of any criminal history record information reported to the FBI and State (if applicable) after the initial processing and retention of criminal transactions. By using fingerprint identification to identify persons arrested and prosecuted for crimes, Rap Back provides a nationwide notice to noncriminal justice authorities regarding subsequent actions. It should be noted that both criminal activity subscription services, FACT and Rap Back, provided and provides the agency with the capability to continually capture criminal activity as related to the requirements of this PREA standard. Additionally, the HRA explained to the auditor during her interview that she runs a national (NCIC) and state (TCIC) criminal history check and applicable child abuse registry check for every employee while conducting their two year re-certification application with TJJD, and she conducts the same checks for all contractors, volunteers, and interns at least every 5 years. This is in addition to the prior FACT Subscription service and current Rap Back service that captures criminal activity on an ongoing basis and reports the activity to the HRA.

Additionally, TAC 344.300 also requires the agency to conduct a criminal history check for:
- an individual in a position requiring certification or eligible for optional certification; and
- an individual who may have direct, unsupervised access to juveniles in a juvenile justice facility or program and who is:
- an employee in a position not requiring certification and not eligible for optional certification;
- a volunteer, an intern, or an individual who provides goods or services under contract.
And, before any individual listed above begins employment or service provision:
- the department or facility must ensure the individual has electronically submitted fingerprints using Fingerprint Applicant Services of Texas (FAST) and verify that the department is able to subscribe to the individual's Fingerprint-Based Applicant Clearinghouse of Texas (FACT) record;
- the department must subscribe to that individual's record in FACT; and
- the department must use the information in FACT to determine if the individual has a disqualifying criminal history as specified in §344.400 of this title.
- The department must maintain a FACT subscription for each individual in a position requiring a criminal history check for as long as the individual remains in such a position. This requirement applies regardless of the date employment or service provision began.

Furthermore, the agency exceeds the requirements of this PREA provision by adhering to TAC §344.302 (Military History Checks Effective Date: 2/1/18). This TAC standard requires the agency to adhere to the following procedures:
- If an individual who is subject to a criminal history check has prior military experience, the department or facility must review the applicant's most recent separation or discharge documents.
- In the event separation or discharge documents reflect character of service that is anything other than "honorable discharge" or "honorably discharged," the department or facility must:
- attempt to obtain authorization from the applicant for the release of information; and
- request additional information from the appropriate governmental entity to determine whether the reason for discharge was the result of disqualifying criminal conduct.
- Before an individual with prior military history begins employment or service provision, the department or facility must use the information described in this section to determine if the individual has a disqualifying criminal history as specified in §344.400 of this title.

- The department or facility must review the most recent separation or discharge documents as described in this section when a currently employed certified officer returns from a period of active duty or is discharged from military service.

The agency documented in the PAQ that out of the 15 persons hired in the past 12 months, 100% (all 15) have had a criminal background record check completed before being hired. The agency also documented in the PAQ that in the past 12 months 8 contracts for services where active, and all 8 contracts included a criminal background record check for each staff covered in the contract who might have contact with residents.

Lastly, the auditor reviewed 8 randomly selected personnel files in order to ensure the agency made 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, and the auditor was able to verify that each of the applicable files included a reference check form with follow-up information related to the employees' work experience, as it relates to this PREA provision. Additionally, the HR Administrator explained to the auditor that the HR department conducts reference checks for all new employees, and there is a reference check form that is utilized when contacting other entities.

115.317 (f):
Policy 3.10 on page 2 outlines the requirements of this provision, and states, "the department shall ask all applicants and employees who may have contact with residents directly about previous misconduct described pursuant to §115.317 (f) in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The department shall also impose upon employees a continuing affirmative duty to disclose any such misconduct."

The auditor was provided a MRJJC form that includes questions for staff to answer related to sexual misconduct pursuant to this provision. The questions include:

- Have you ever engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution?
- Have you ever been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, over or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?
- Have you ever been civilly or administratively adjudicated to have engaged in the activity described in question #2 (above).

This form also includes the following statements:

- If you are hired or if you are a current Jefferson County Juvenile Probation (JCJP) employee, you have the continuing affirmative duty to immediately disclose to JCJP human resources any misconduct that would result in a "yes" to any of the above three questions.
- Providing untruthful answers to the above questions or failing to disclose any misconduct that would result in a "yes" answer to any of the above questions will be ground for termination through the disciplinary process."

The auditor reviewed a random sample of 22 PREA question forms that were completed for

2019 (22 out of a possible 27 certified staff members- 81%), and each form included the staff member's printed name, last four of their social security number, signature, and date. The auditor also reviewed 8 randomly selected certified staff member's personnel files, and discovered past PREA question forms from as far back as 2016. It was determined that the agency began using the PREA question form when they were audited last for PREA in 2016, and every file reviewed, whose employment began before 2016, included the 2016 form signed by each employee. The auditor also confirmed that one of the employees' who received a promotion in 2018, did complete a PREA question form for this promotion. Additionally, the auditor reviewed two (out of the 8 randomly selected personnel files) employee files whose date of employment was within the past 12 months, and both these files included the PREA question forms completed by the corresponding staff member before they began working in the facility with residents.

The auditor also determined that each employee evaluation reviewed from 2016 to 2019 (from the eight randomly selected personnel files) included a PREA question form completed for the applicable evaluation; although, the auditor did not find any evaluation from 2017. The auditor discussed this finding with the Casework Manager, and she explained that the department strives to complete annual evaluations and the applicable policy includes procedures for conducting evaluations annually for each employee. Additionally, it was explained that some supervisors are better at completing the evaluations than others and that this is why there were inconsistencies found with the missing 2017 evaluations. The Casework Manager advised that there is a lot of turnover in detention and supervisors have a difficult time managing their responsibilities. In addition, she explained that the agency does not complete evaluations for part-time staff at all, but there is definitely an ongoing affirmative duty to report the described misconduct pursuant to this PREA standard. The auditor determined through reviewing the FAQ related to this PREA provision (https://www.prearesourcecenter.org/node/3601) that the agency is in compliance with this PREA provision even though they did not complete evaluations in 2017 or complete evaluations for part-time staff. The FAQ from the PRC's website states that: "If the agency does not use written applications, written self-evaluations, or conduct interviews under the circumstances indicated in standard 115.17(f), it has no obligation under this standard to begin these practices. However, the agency does have the obligation to establish a continual affirmative duty to disclose misconduct. The agency must impose on employees the affirmative duty to report any misconduct described in standard 115.17(a) [i.e., paragraph (a) of the standard] at any time that it occurs." The agency, as noted above, did sufficiently demonstrate to the auditor that each of the randomly selected PREA question forms reviewed (22 out of an available 27 of current JSOs) included a statement establishing a continual affirmative duty to disclose misconduct. Furthermore, as noted above in this subsection, Policy 3.10 on page two also outlines the same continual affirmative duty to disclose.

115.317 (g):
Agency Policy 3.10 on page 2 includes the requirements of this provision and states, "material omissions regarding such misconduct (sexual misconduct pursuant to §115.317), or the provision of materially false information, shall be grounds for termination."

The auditor reviewed the last internal investigation the agency conducted regarding an incident of sexual misconduct by a staff member from 2016, and this investigation did not

include information related to a staff member omitting or providing false information. This investigation is discussed in detail in the explanation of determination for PREA standard §115.371 of this report.

115.317 (h):
Policy 3.10 on page two outlines the requirements of this provision and states, “unless prohibited by law, the department shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request in writing from an institutional employer for whom such employees has applied to work.”

The HR Administrator advised during her interview that there is a form that the HR department will complete when they receive a request from another agency, and this form provides information on substantiated allegations of sexual abuse or sexual harassment involving a former employee, unless prohibited by law.

Additionally, TAC Chapter 344.400 requires all juvenile justice entities who employ certified JSOs and JPOs to comply with the following standard provisions:

- If a department receives notification of an arrest for potentially disqualifying criminal conduct of a person hired in the capacity of a certified officer, the department must notify TJJD’s certification office in writing of the alleged offense no later than 10 calendar days after receiving notice of the arrest.

- If a department receives notification of a conviction for disqualifying criminal conduct of a person hired in the capacity of a certified officer, the department must notify TJJD’s certification office in writing of the offense no later than 10 calendar days after receiving notice of the conviction.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.318 Upgrades to facilities and technologies

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.318

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)

Interviews:

- Agency Head (Director of JCJPD)
- Superintendent (also the PREA Coordinator/PC)

Site Review Observations:

During the onsite audit, the auditor observed that the MRJJC did not include any recent substantial expansion or modification to the existing facility. The auditor inspected the entire facility, and each area inspected was similar in construction and consistent with the overall design of the Complex. The auditor was able to observe the facility's video monitoring system while onsite, and it was explained to the auditor by the PC and a Casework Supervisor that their latest video system upgrade now provides the facility with the capability to continually record up to 3 months of video per DVR and sometimes up to 4 months. This allows the facility to review incidents that were not saved on a different media source, other than the automatically saved DVR, up to 3 to 4 months prior to the current day of the review.

Explanation of determination:

115.318 (a) & (b):
The agency reported in the PAQ for this PREA standard that they have not acquired a new facility or made a substantial expansion or modification to the existing facility. Furthermore, during the onsite monitoring visit, the auditor was made aware by the PC that the agency added four cameras in the counselor rooms after the 2016 PREA audit and just recently updated their video monitoring software. It was reported by the PC that the facility has in operation 89 cameras and that their camera software was just recently upgraded (approximately a month prior to the onsite). The auditor was provided access to view the camera system in the Control Room, in the Detention Superintendent's office, and in the Casework Supervisor's office. Each monitor that the auditor observed provided a clear and sharp image of the area being monitored. The Casework Supervisor and Superintend advised the auditor that their latest video system upgrade now provides the facility with the capability to continually record up to 3 months of video per DVR and sometimes up to 4 months. This allows the facility to review incidents that were not saved on a different media source, other than the automatically saved DVR, up to 3 to 4 months prior to the current day of the review. The Superintendent advised that the cameras only record when there is movement, and therefore this makes the extended record time possible. The upgrade in picture quality and additional record time that the new video system software includes greatly enhances the

agency's ability to protect residents and staff from sexual abuse and sexual harassment. Additionally, the added playback recording time allows the agency to review incidents that allegedly occurred up to four months prior, and this will assist the agency with reviewing and investigating incidents that are reported weeks or months after the alleged incident occurred.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.321 Evidence protocol and forensic medical examinations

Auditor Overall Determination: Exceeds Standard

Auditor Discussion

115.321

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 12.5 (Sexual Abuse & Mistreatment) / Last updated: 09/02/2016
- Investigative File from Staff Sexual Misconduct allegation from 2016
- TJJD Internal Investigation report
- JCJPD Termination Letter
- Grievance from 2016 allegation
- JCJPD Incident Report from 2016 allegation
- Witness statements from 2016 allegation
- Documentation of staff suspension for 2016 allegation
- Documentation of law enforcement notification for 2016 allegation
- Disposition document from TJJD for 2016 allegation
- Memo from the PREA Coordinator (PC) in regards to SANE/SAFE exams
- Cooperative Working Agreement between Rape and Suicide Crisis of Southeast Texas and Jefferson County Juvenile Probation Department (JCJPD) for 2019 – 2021 (as well as the previous agreement active from 2016 – 2018)
- Texas Department of Health Services Licenses for the Agency's Mental Health Provider (MHP)
- Email communications from the Chief of JCJPD and the Jefferson County's Sheriff's Department Investigative Unit
- Information for Parents, Guardians, and Custodians Regarding PREA form
- Email communications from the Chief of JCJPD to SANE nurses
- Garth House website (https://www.garthhouse.org/)
- Garth House (Mickey Mahaffy Children's Advocacy Program, Inc) Best Practice Guidelines: Jefferson County Working Protocols (Effective from 2016 to present day)
- Texas Administrative Code (TAC) Title 37, Chapter 358

Interviews:

- 12 Randomly Selected Staff (Juvenile Supervisor Officers- JSOs)
- SANE/SAFE Nurse
- Crisis Specialist from the Rape Crisis of SE TX
- PREA Coordinator (PC) / Detention Superintendent
- Executive Director of the Garth House

Site Review Observations:

During the onsite audit, the auditor reviewed the agency's last sexual misconduct investigation that was conducted in 2016. The agency reported to the auditor that this 2016 investigation was the latest sexual type allegation reported, and it should be noted that this investigation

involved alleged staff sexual misconduct toward a resident (as detailed in this standard explanation of determination). It was reported to the auditor by the PC that there was one targeted resident in the current detention population that reported on the agency's Behavioral Screen (Risk Screening) of being a victim of sexual abuse while in the community. During the onsite visit, the agency did not report to the auditor of a resident who reported sexual abuse that allegedly occurred in the facility (MRJJC), and therefore the auditor did not have the opportunity to interview such a resident. The auditor also verified that no such resident was currently in the facility who reported sexual abuse that allegedly occurred in a facility through conducting a total of 11 resident interviews (11 out of a possible 13 available residents while the auditor was onsite). Each resident advised during their interview that they were not a victim of sexual abuse that occurred in the facility.

Explanation of determination:

115.321 (a):
Agency Policy 12.5 on page 7 outlines the agency's requirements to ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. The JCJPD conducts administrative investigations, and the Jefferson County Sheriff Department is required to conduct criminal investigations. Additionally, Policy 12.5 on page 2 explains that all allegations of sexual abuse or sexual harassment involving a juvenile shall be immediately referred to the Jefferson County Sheriff's Department (JCSD) and Texas Juvenile Justice Department (TJJD). It should be noted that the investigative division for TJJD is called the Administrative Investigative Division or AID. However they are now under the umbrella of the Office of the Inspector General (OIG) since they are technically peace officers. Therefore, they actually perform both functions- as an administrative and criminal investigative unit, as applicable for each unique case referred. First, as administrative investigators, and, if necessary, they work in conjunction with law enforcement and the OIG for criminal investigations. The facility also provided the auditor with an email communication from the Chief of JCJPD to the Jefferson County Sheriff Department Investigative Unit, requesting the Investigative Unit to adhere to the applicable PREA standard for conducting a criminal investigation, specifically to follow a uniform evidence protocol (as explained in more detail in subsection (b) of this standard explanation). Additionally, Policy 12.5 on page 5 describes that the agency will follow a uniform evidence protocol that is developmentally appropriate for youth for responding to allegations of sexual abuse. The evidence protocols included in the Policy include, but are not limited to, the following uniformed procedures:

- Take immediate steps to protect the victim by ensuring that the alleged victim and alleged perpetrator are physically separated pending an investigation, which may include, but is not limited to:
- dorm transfer or
- other placement within the facility (i.e., Isolation Room).
- Preserve evidence that may be pertinent to an investigation of the matter.
- Staff shall preserve and protect any crime scene until law enforcement arrives to investigate and collect any evidence.
- Staff receiving the report of sexual abuse shall request that the alleged victim and perpetrator to not shower, wash, change clothes, brush teeth, urinate, defecate, smoke, or eat to preserve evidence.
- Report the allegation to TJJD and JCSD.

- Notify the parent/guardian/attorney
- Promptly refer the child to health care and/or MHP for examination and treatment.
- Timely, unimpeded access to emergency treatment and crisis intervention services.
- Transport a victim of sexual abuse immediately to the appropriate medical facility which can provide for medical examination by a SANE or equally qualified medical personnel.
- Provide a victim of any type of sexual abuse the following: a mental and medical health assessment as soon as possible, protective housing as needed, and provided emergency counseling to include independent certified rape crisis counseling, if desired by the victim.

Additionally, the JCJPD's website includes an "Information for Parents, Guardians, and Custodians Regarding PREA" form that includes information related to the agency referring all alleged incidents of sexual abuse and sexual harassment in the MRJJC to the JCSD and TJJD for criminal investigation. The PREA Coordinator (PC) informed the auditor, and the auditor was able to confirm onsite, that the JCSD is located next to the MRJJC (within approximately 100 yards, on the same road). The PC also explained that for any type of assault that occurs in the MRJJC, the JCSD is immediately contacted and sends an officer to the Center without delay.

The auditor interviewed 12 randomly selected JSO staff who all clearly indicated to the auditor that when an allegation of sexual abuse or sexual harassment is made, the JCJPD conducts the administrative investigation and the JCSD and TJJD conducts the criminal investigation. The staff members interviewed adequately explained the agency's evidence protocols of separating the victim and perpetrator, preserving and protecting the scene (to protect usable physical evidence); the importance of immediately reporting to a supervisor and law enforcement (JCSD who collects physical evidence); advising the victim and perpetrator to not do anything that could possible destroy evidence- such as to not shower, wash, brush teeth, eat or drink, use the restroom, change out, etc. (i.e., staff also explained that the residents involved would be moved to an isolation room is possible, which does not include a sink or toilet); and contacting mental and/or medical to assist if needed (calling 911 if emergency services are needed). The staff interviewed also were able to identify each of the administrative investigators the MRJJC can utilize in the case of an administrative investigation being conducted.

Furthermore, the auditor reviewed the most recent allegation of a sexual abuse or sexual harassment type incident, which was an allegation of staff sexual misconduct from 2016. This investigative file was provided to the auditor while he was onsite, and the files included the following documents adequately demonstrating the agency's use of a uniformed evidence protocol:

- Policy 12.5 (Sexual Abuse and Mistreatment) and Policy 9.3 (Juvenile Supervision and Movement)
- Documentation of the alleged sexual comment made by the staff member to the resident.
- Witness statements from staff, residents, and a volunteer.
- Grievance written by the resident victim that initiated the abuse investigation.
- Incident report from a staff member who was allegedly involved.
- Termination Documents (stating a violation of the zero tolerance policy for any form of sexual misconduct, abuse, or sexual harassment).
- An Investigative Report outlining the investigation from beginning to end.

- Disposition documentation from TJJD stating that the preponderance of evidence did not determine the incident met the statutory definition of abuse, neglect, or exploitation.
- A Case Number
- Documentation that the JCSD was contacted, but no criminal investigation was initiated due to TJJD's findings.

Additionally, it should be noted that the agency is required to adhere to the following TAC Standard, §358.300:

Duty to Report.
An employee, volunteer, or other individual working under the auspices of a facility or program must report the death of a juvenile or an allegation of abuse, neglect, or exploitation to TJJD and local law enforcement if he/she:
- witnesses, learns of, or receives an oral or written statement from an alleged victim or other person with knowledge of the death of a juvenile or an allegation of abuse, neglect, or exploitation; or
- has a reasonable belief that the death of a juvenile or abuse, neglect, or exploitation has occurred.

Sexual Abuse or Serious Physical Abuse.
- Time Frames for Reporting.
- A report of alleged sexual abuse or serious physical abuse must be made to local law enforcement immediately, but no later than one hour after the time a person gains knowledge of or has a reasonable belief that alleged sexual abuse or serious physical abuse has occurred.

And, Chapter §358.400:

Investigation Requirement.
In every case in which an allegation of abuse, neglect, or exploitation or the death of a juvenile has occurred, an internal investigation must be conducted. The investigation must be conducted by a person qualified by experience or training to conduct a comprehensive investigation. The internal investigation must be initiated immediately upon the chief administrative officer or their respective designees gaining knowledge of an allegation of abuse, neglect, or exploitation or the death of a juvenile. Departments, programs, and facilities must have written policies and procedures for conducting internal investigations of allegations of abuse, neglect, or exploitation or the death of a juvenile. The internal investigation must be conducted in accordance with the policies and procedures of the department, program, or facility.

115.321 (b):
Agency Policy 12.5 on page 5 states that the MRJJC will follow a uniform evidence protocol when responding to allegations of sexual abuse, and the evidence protocol must be developmentally appropriate for youth. The PREA Coordinator provided the auditor with a signed memo describing that the JCJPD utilized the National Protocol for Sexual Assault Medical Forensic Exams when developing Policy 12.5. The agency also provided an active (2019-2021) Cooperative Working Agreement that is signed by the Chief of the JCJPD and the Executive Director of the Rape and Suicide Crisis of S.E. Texas, and an active Working

Protocols document that is signed by the Jefferson County Judge, Jefferson County DA, Chief of the JCJPD, the Executive Director of the Garth House, and 15 other leaders from surrounding law enforcement jurisdictions.

Upon the auditors review of each supplemental document provided by the agency (Policy 12.5, Cooperative Working Agreement from the Rape Crisis Center, Working Protocols Agreement from the Garth House, and the memo from the PC), the auditor determined that the agency's investigative protocols are developmentally appropriate for youth, uniformed, and based on the most recent edition of the DOJ's publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescent."

115.321 (c):
Policy 12.5 on page 10 outlines the agency's requirement to provide all juveniles who experience sexual abuse access to forensic medical examinations whether on-site or at an outside facility, without financial cost, where evidentiary or medically appropriate. Such exams shall be performed by a SAFE or SANE where possible. If SAFE/SANE cannot be made available, the examination can be performed by other qualified medical practitioners. The department shall document its efforts to provide a SAFE/SANE. Additionally, the Cooperative Working Agreement with the Rape Crisis Center of SE TX also documents that the Rape Crisis Center agrees to referring the sexual assault survivor to Christus St. Elizabeth Hospital SANE Team, Child Abuse & Forensic Services, Baptist Hospital of SE TX Beaumont or the Medical Center of SE TX SANE Team, as appropriate. The Garth House Working Protocols document outlines the Garth House's responsibility of ensuring a victim of sexual abuse is referred to the appropriate hospital for a Forensic Nurse Examination. It is explained in the document that the Garth House coordinates with two Forensic Nurse Examiner programs to ensure the best outcomes for investigations and clients. The document breaks down the procedures to include protocols for an acute exam (within 96 hours of offense), for a non-acute (more than 96 hours since offense), and for an emergency situation in which the child is complaining of pain or there is evidence of injury. Additionally, it is explained that the Forensic Nurse Examiner:
- Provides medical forensic evaluation of suspected child abuse victims including appropriate documentation (written and/or photographic) and evidence collection.
- Provides expertise in differentiating medical findings indicative of abuse versus those with other explanations.
- Helps ensure the health and well-being of the child by providing appropriate education and reassurance for the child and caregiver.
- Makes referrals as needed for other medical care.
- Attends Multi-Disciplinary Team (MDT) Case Review and provides relevant information to team members.
- Provides ongoing education for the MDT both through formal trainings and informal consultation.

The PC provided the auditor with a signed memo stating that the MRJJC has not had any incidents reported that required a SAFE/SANE exam. Additionally, the agency reported in section 115.321 (c)-9 and -10 that they have not had a SANE/SAFE exam performed in the past 12 months prior to the onsite audit.

Additionally, as noted earlier in this section of the report, the auditor was never made aware of a child being sexually abused in the facility; therefore, no resident who experienced abuse in

the facility was available to be interviewed.

The auditor was able to interview a SANE/SAFE nurse that contracts with the Baptist Hospital (hospital who accepts residents from MRJJC), and she explained that she works from Child Abuse Forensic Services, Inc. The SANE nurse described her position with the company, as the Director, and she provided her qualifications- CPCA SANE. The nurse stated she has never conducted a SANE/SAFE exam on a resident from the MRJJC, but that she would be able to if a resident of sexual abuse was referred to Baptist Hospital. She also explained that if she is unavailable for an exam, the hospital can reach out to other certified SANE/SAFE nurses who can respond immediately.

The Executive Director of the Garth House was also interviewed by the auditor, and she advised that the Working Protocols agreement between her agency and JCJPD has been in effective for over 20 years. She described how the referring law enforcement agency sets up the SANE/SAFE exams for victims of sexual abuse, and that historically the transporting law enforcement agency has paid for the cost of the exam. Although, the Executive Director informed the auditor that there is current legislation that may change the financial responsibilities for these type of exams to Child Protective Services. But regardless of who is responsible of paying for the SANE/SAFE, the victim or the victim's family is never charged.

Furthermore, the auditor also interviewed a Crisis Specialist from the Rape Crisis of SE TX (RCST), and she verified that the Cooperative Working agreement was an active written agreement between the JCJPD and her organization. The Specialist from RCST explained that there are two hospitals in Beaumont in which a juvenile victim of sexual abuse can be referred for a SANE/SAFE exam- Christus St. Elizabeth Hospital (who has a SANE team who specializes in child abuse and forensic services) and Baptist Hospital of SE TX Beaumont SANE Team. She also described how her organization is a 504 non-profit organization; therefore, all services provided are free of charge (including the SANE/SAFE exams).

The auditor interviewed a targeted resident who reported to an intake officer during the intake process that she had been sexually assaulted while in the community prior to her last detention (reported on the agency's risk screening- Behavioral Screening, as verified by the auditor). The resident informed the auditor that when she first made the outcry during her last detention stay a few months ago, the report was for an incident that occurred in 2018 that remains to be an open investigation with the Beaumont Police Department. She also explained that during her last detention stay, she was introduced to the Garth House organization, and they arranged for a SANE exam. The SANE exam was performed at Baptist Hospital and the Garth House assigned her an advocate that was with her throughout the process and met with her afterwards at the Detention Center. The resident stated that this all occurred during her last detention stay, and during this most recent detention, she explained that the MRJJC provided her a follow-up with the agency's MHP due to reporting the prior abuse during this most recent intake. The resident explained that this face-to-face meeting with the MHP occurred the day after being admitted.

The auditor determined that the agency substantially exceeds the requirement of this provision by ensuring through multiple hospitals (Christus St. Elizabeth Hospital SANE Team, Child Abuse & Forensic Services, Baptist Hospital of Southeast Texas Beaumont, or the Medical Center of Southeast Texas SANE Team) and multiple organizations (Rape and

Suicide Crisis of Southeast Texas and the Garth House) that a resident who experienced sexual abuse is provided access to a forensic medical examination.

115.321 (d) & (e):
Agency Policy 12.5 on page 9 states that the department shall attempt to make available to the victim (of sexual abuse) a victim advocate from the Rape and Suicide Crisis Center of South East Texas, and this policy outlines all the other required elements of this PREA standard provision. Furthermore, Policy 12.5 on page 10 documents that if requested by a victim of sexual abuse, the victim advocate, qualified agency staff member, or qualified community-based organization staff member shall accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals.

Additionally, as noted above in this standard explanation, the JCJPD has an active Cooperative Working Agreement with the Rape and Suicide Crisis of SE TX, Inc (RSCST). This agreement outlines a collaborate effort by the JCJPD and the Rape and Suicide Crisis agency to provide a continuum of services as needed for sexual assaulted or sexually abused youth housed at the MRJJC. The Agreement requires the JCJPD to:
- Contact and report to the RSCST that a juvenile has been sexually assaulted or sexually abused while at the MRJJC or occurred prior to arriving at MRJJC but reported while at the facility.
- Contact and report to the RSCST upon the request of a juvenile victim of sexual assault or sexual abuse while at the MRJJC or occurred prior to arriving at the MRJJC but reported while at the facility.
- Allow a juvenile victim at MRJJC to contact a representative of the RSCST for assistance.
- Allow a representative of the RSCST access to the juvenile victim.

The Agreement also outlines the responsibilities that the RSCST agrees to, which include:

- Refer sexual assault survivors for a SANE/SAFE exam (as documented in subsection (c) of this PREA standard explanation).
- Demonstrate an average 60 minute response time from time call is received to time advocate arrives in the emergency department.
- Follow established protocols with the associated hospital that is conducting the SANE/SAFE exam for advocates in the examining room.
- Be available for survivors of all ages, their family members and friends.
- Maintain communication and contact with Sexual Abuse Review Team (SART) and other involved agencies, including regular participation at the Southeast Sexual Assault Task Force meeting.

The auditor also interviewed a Crisis Specialist from the RSCST that explained that an advocate from her agency would immediately be provided to a victim of sexual abuse that is referred from the MRJJC. She described that an advocate stays with the victim throughout the initial meeting and through the aftercare process. The RSCST was described to be a non-profit 504 organization, and the victim and the victim's family is never charged for any services provided by the RSCST. The Crisis Specialist explained that her office is open and available during normal business hours; although, if the services of the RSCST are required after hours, there is a hotline number that is answered 24/7.

Additionally, the JCJPD provided the auditor with a Working Protocols agreement between the Agency and Garth House (Mickey Mehaffy Children's Advocacy Program, Inc) that includes victim advocacy services for a resident in the MRJJC who has experienced sexual abuse. The Garth House is described in the document as responsible for facilitating the coordination of a multidisciplinary team (MDT) that responds to allegations of child abuse in Southeast Texas and provides victim advocacy, case tracking, and mental health services. The Working Protocols includes the following advocacy services:

- Orients the child and family to the interview process including a brief tour of the interview room and explanation of the camera and recording system.
- Meets with the caregiver during the forensic interview to provide support and information regarding the MDT and criminal justice process.
- Provides crisis intervention including assessing the need for other services.
- Provides written information including the booklet, "A Handbook for Parents" with names and contact information of the investigators involved.
- Provides the information for caregivers regarding the rights of crime victims, refers the family to the Crime Victims Assistance Office and provides Crime Victims Compensation applications.
- Makes referrals as needed to other community resources and provides information about counseling.
- Follows the case through the legal system updating the status of the case in Case Tracking including final disposition.
- Maintains contact with the family during the investigation and prosecutorial processes.

The auditor interviewed a Crisis Specialist from the RSCST who explained that an advocate from her agency would be assigned to provide advocacy services, as outlined in the Cooperative Working Agreement between JCJPD and RSCST, to a juvenile victim of sexual abuse that is referred from the JCJPD. She advised the auditor that victim advocacy services would also be provided to the victim's family and that all services would be at no cost to the victim or victim's family.

Additionally, the Executive Director of the Garth House was interviewed by the auditor, and she confirmed that the Working Protocols Agreement is an active and working agreement between the JCJPD and the Garth House.

The JCJPD also explained to the auditor that the agency employs a fulltime qualified staff member that is available onsite at any time, in the case that a rape crisis center or Garth House advocacy person is not available for a victim of sexual abuse. The qualified staff member is the agency's Mental Health Provider (MHP), and the agency provided the auditor with the MHP's licensing documentation from the Texas Department of State Health Services. The documentation proves that the agency's MHP holds a current State license as a Sex Offender Treatment Provider (LSOTP) and as a Professional Counselor (LPC).

The auditor interviewed a targeted resident who reported to an intake officer during the intake process that she had been sexually assaulted while in the community prior to her last detention (reported on the agency's risk screening- Behavioral Screening, as verified by the auditor). The resident informed the auditor that when she first made the outcry during her last detention stay a few months ago, the report was for an incident that occurred in 2018 that

remains to be an open investigation with the Beaumont Police Department. She also explained that during her last detention stay, she was introduced to the Garth House organization, and they arranged for a SANE exam and advocate. The SANE exam was performed at Baptist Hospital and the Garth House assigned her an advocate that was with her throughout the process and met with her afterwards at the Detention Center. The resident stated that this all occurred during her last detention stay, and during this most recent detention, she explained that the MRJJC provided her a follow-up with the agency's MHP due to reporting the prior abuse during this most recent intake. The resident explained that this face-to-face meeting with the MHP occurred the day after being admitted.

The auditor determined that the agency substantially exceeds the requirement of this provision by ensuring through multiple avenues (Rape and Suicide Crisis of Southeast Texas, the Garth House, and the agency's own MHP) that a resident who experienced sexual abuse is provided victim advocacy services.

115.321 (f):
The MRJJC provided the auditor with an email communication from the Chief of JCJPD to the Jefferson County Sheriff Department Investigative Unit, requesting the Investigative Unit to adhere to the applicable PREA standard for conducting a criminal investigation, specifically to follow a uniform evidence protocol (as explained in more detail in subsection (b) of this standard explanation).

As described in subsection (b) of this PREA standard explanation of determination, the agency provided an active (2019-2021) Cooperative Working Agreement that is signed by the Chief of the JCJPD and the Executive Director of the Rape and Suicide Crisis of S.E. Texas, and an active Working Protocols document that is signed by the Jefferson County Judge, Jefferson County DA, Chief of the JCJPD, the Executive Director of the Garth House, and 15 other leaders from surrounding law enforcement jurisdictions. Upon the auditors review of each supplemental document provided by the agency (Policy 12.5, Cooperative Working Agreement from the Rape Crisis Center, Working Protocols Agreement from the Garth House, and the memo from the PC), the auditor determined that the agency's that are not involved with the JCJPD that assist with conducting administrative and/or criminal investigations have agreed to follow the requirements of PREA Standard §115.321 (specifically provisions (a) – (e), as described in this report for each provision explanation for 115.321). It should be noted that the Garth House Working Protocols documentation includes a multi-disciplinary team (MDT) that includes the following law enforcement and prosecuting agencies and other organizations and individuals that provides the services as required by the PREA standard:

- Jefferson County District Attorney's Office
- Jefferson County Sheriff's Office (who would be contacted for any sexual abuse or sexual harassment allegation that allegedly occurred in the MRJJC)
- Beaumont PD
- Port Arthur PD
- Port Neches PD
- Nederland PD
- Groves PD
- Beaumont ISD PD
- Texas Department of Family & Protective Services (TDFPS)- Child Protective Services (CPS)

- Christus Southeast Texas Health System
- Child Abuse and Forensic Services, Inc.
- CASA of Southeast Texas, Inc.
- Jefferson County Crime Victim's Assistance Center
- Garth House Multidisciplinary Team Coordinator/Intake Screener
- Garth House Forensic Interviewer
- Garth House Family Advocate
- Garth House Mental Health Professional

115.321 (g):
N/A. The auditor is not required to audit this provision.

115.321 (h):
N/A: The agency utilizes professionals from the Rape and Suicide Crisis of Southeast TX & the Garth House (Mickey Mehaffy Children's Advocacy Program) to conduct all the PREA related requirements of this standard. Through an analysis of agency Policy 12.5, supplementary documents (Cooperative Agreements and Working Protocols Agreement), and interviews with specialized staff as documented throughout this standard's explanation of determination, the auditor has determined that the agency's MHP would only be utilized as a supplementary piece of the services that would be provided to a resident who has experienced sexual victimization. With that said, it should be noted that the MHP is a licensed Sex Offender Treatment Provider (LSOTP) and licensed Professional Counselor (LPC), who, per her interview with the auditor, also has received certifications as a Forensic Counselor, Clinical Certified Domestic Violence Counselor, Master Addiction Counselor, Anger Resolution Therapist. She also advised the auditor that she is in her second year of her Doctoral program in psychology. The MHP also explained that she completes recurring training every year related to juvenile management of sex offenders (24 hours a year), and that PREA training, as applicable to this PREA standard, is included in this annual training.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency substantially exceeds all elements of this standard. No corrective action is required.

115.322 Policies to ensure referrals of allegations for investigations

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.322

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 12.5 (Sexual Abuse & Mistreatment) / Last updated: 09/02/2016
- Agency Policy 15.12 (Notification and Reporting Illness, and Investigating Abuse, Exploitation, or Death) / Last updated: 06/16/2016
- JCJPD website (https://co.jefferson.tx.us/juvenile/Main.htm)
- Investigative Report from Staff Sexual Misconduct allegation from 2016
- Email communications from the Chief of JCJPD and the Jefferson County's Sheriff's Department Investigative Unit
- Information for Parents, Guardians, and Custodians Regarding PREA form
- Texas Administrative Code (TAC) Title 37, Chapter 358
- TJJD Internal Investigation report
- JCJPD Termination Letter
- Grievance from 2016 allegation
- JCJPD Incident Report from 2016 allegation
- Witness statements from 2016 allegation
- Documentation of staff suspension for 2016 allegation
- Documentation of law enforcement notification for 2016 allegation
- Disposition document from TJJD for 2016 allegation

Interviews:

- Agency Head (Director of JCJPD)
- Investigative Staff
- Randomly Selected Staff (JSOs)

Site Review Observations:

During the onsite audit, the auditor reviewed the agency's last sexual misconduct investigation that was conducted in 2016. The agency reported to the auditor that this 2016 investigation was the latest sexual type allegation reported, and it should be noted that this investigation involved alleged staff sexual misconduct toward a resident. This investigation is described in the explanation of determination sections of this PREA standard and standard §115.321.

Explanation of determination:

115.322 (a), (b), and (c):
Agency Policy 12.5 on page 7 outlines the agency's requirements to ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. The JCJPD conducts administrative investigations, and the Jefferson

County Sheriff Department is required to conduct criminal investigations. Additionally, Policy 12.5 on page 2 explains that all allegations of sexual abuse or sexual harassment involving a juvenile shall be immediately referred to the Jefferson County Sheriff's Department (JCSD) and the Texas Juvenile Justice Department (TJJD) for criminal investigation. It should be noted that the investigative division for TJJD is called the Administrative Investigative Division or AID. However they are now under the umbrella of the Office of the Inspector General (OIG) since they are technically peace officers for the State of TX. Therefore, they actually perform both functions- as an administrative and criminal investigative unit, as applicable for each unique case referred. First, as administrative investigators, and, if necessary, they work in conjunction with law enforcement and the OIG for criminal investigations. The auditor was informed by the PC that the agency documents all administrative investigations on an official TJJD Internal Investigation report (that includes the documentation of the referral to law enforcement for criminal investigation, as verified by the auditor), and that the JCSD and TJJD document on their own reporting forms the process and disposition of the criminal investigation.

Agency Policy 15.12 also outlines the agency's procedures for ensuring referrals of allegations of sexual abuse and sexual harassment are investigated. On page 1 and 2 of Policy 15.12, the Detention Superintendent or designee is described to be responsible for reporting abuse and completing and submitting a TJJD incident report form to TJJD within 24 hours. Additionally, this Policy states that the Department (MRJJC) shall conduct an internal investigation in all allegations of child abuse, exploitation, or neglect; and that all cases of alleged abuse, exploitation, neglect, or death in the Detention Center shall be reported to local law enforcement (JCSD) pursuant to 261 of the Texas Family Code within 24 hour of the incident. The Policy also lists the Jefferson County Sheriff's Department Criminal Investigation Division contact number.

Additionally, the JCJPD's website includes an "Information for Parents, Guardians, and Custodians Regarding PREA" form that includes information related to the agency referring all alleged incidents of sexual abuse and sexual harassment in the MRJJC to the JCSD and TJJD for criminal investigation. The auditor was also able to verify that the agency's website included the JCJPD Policy 12.5, which outlines the responsibilities of the JCJPD and TJJD for conducting their own criminal investigations, as well as the responsibilities of the JCJPD to conduct their own administrative investigation. The PREA Coordinator (PC) informed the auditor, and the auditor was able to confirm onsite, that the JCSD is located next to the MRJJC (within approximately 100 yards, on the same road). The PC also explained that for any type of assault that occurs in the MRJJC, the JCSD is immediately contacted and sends an officer to the Center without delay.

The auditor interviewed 12 randomly selected JSO staff who all clearly indicated to the auditor that when an allegation of sexual abuse or sexual harassment is made, the JCJPD conducts the administrative investigation and the JCSD and TJJD conducts the criminal investigation.

The agency reported in the OAS on the PAQ for this PREA provision that they had zero allegations of sexual abuse and sexual harassment in the past 12 months; therefore, the agency also reported that they conducted zero administrative investigations and the JCJPD and TJJD conducted zero criminal investigations in the past 12 months.

Furthermore, the auditor reviewed the most recent allegation of a sexual abuse or sexual harassment type incident, which was an allegation of staff sexual misconduct toward a resident from 2016. Per the investigative reporting documents, the alleged staff member was immediately suspended by the Detention Superintendent (PC) as soon as the report was made to the agency, the Jefferson County Sheriff's Department and TJJD were notified immediately to conduct criminal investigations, and the JCJPD initiated their own administrative investigation. The documents included in this investigative file from 2016 included the following documents:

- Policy 12.5 (Sexual Abuse and Mistreatment) and Policy 9.3 (Juvenile Supervision and Movement)
- Documentation of the alleged sexual comment made by the staff member to the resident.
- Witness statements from staff, residents, and a volunteer.
- Grievance written by the resident victim that initiated the abuse investigation.
- Incident report from a staff member who was allegedly involved.
- Termination Documents (stating a violation of the zero tolerance policy for any form of sexual misconduct, abuse, or sexual harassment).
- An Investigative Report outlining the investigation from beginning to end.
- Disposition documentation from TJJD stating that the preponderance of evidence did not determine the incident met the statutory definition of abuse, neglect, or exploitation.
- A Case Number
- Documentation that the JCSD was contacted, but no criminal investigation was initiated due to TJJD's findings.

It should be noted that TJJD concluded in their investigation report that the preponderance of evidence did NOT determine the incident met the statutory (TX) definition of abuse, neglect, or exploitation; therefore, criminal charges were never petitioned. Furthermore, the JCJPD did contact the Jefferson County Sheriff's Department (JCSD) to report the alleged staff sexual misconduct (as required by JCJPD Policy 12.5); although, the JCSD did not conduct a full criminal investigation due to the disposition found by TJJD (per the PC). The JCJPD completed their own administrative investigation and found that the alleged staff member was in violation of Department Policies 12.5 and 9.3- zero tolerance for any form of sexual misconduct, abuse, or sexual harassment- and as a result, terminated from employment.

Additionally, it should be noted that the agency is required to adhere to the following TAC Standard, §358.300 (which is available to the public on the TJJD's website (http://www.tjjd.texas.gov/publications/default.aspx):

Duty to Report.
An employee, volunteer, or other individual working under the auspices of a facility or program must report the death of a juvenile or an allegation of abuse, neglect, or exploitation to TJJD and local law enforcement if he/she:
- witnesses, learns of, or receives an oral or written statement from an alleged victim or other person with knowledge of the death of a juvenile or an allegation of abuse, neglect, or exploitation; or
- has a reasonable belief that the death of a juvenile or abuse, neglect, or exploitation has occurred.

Sexual Abuse or Serious Physical Abuse.
- Time Frames for Reporting.
- A report of alleged sexual abuse or serious physical abuse must be made to local law enforcement immediately, but no later than one hour after the time a person gains knowledge of or has a reasonable belief that alleged sexual abuse or serious physical abuse has occurred.

And, Chapter §358.400:

Investigation Requirement.
In every case in which an allegation of abuse, neglect, or exploitation or the death of a juvenile has occurred, an internal investigation must be conducted. The investigation must be conducted by a person qualified by experience or training to conduct a comprehensive investigation. The internal investigation must be initiated immediately upon the chief administrative officer or their respective designees gaining knowledge of an allegation of abuse, neglect, or exploitation or the death of a juvenile. Departments, programs, and facilities must have written policies and procedures for conducting internal investigations of allegations of abuse, neglect, or exploitation or the death of a juvenile. The internal investigation must be conducted in accordance with the policies and procedures of the department, program, or facility.

In addition, the JCJPD Chief explained in this interview with the auditor that his Department immediately contacts the Jefferson County Sheriff's Department and TJJD so that a criminal investigation can be initiated, when applicable, and that for all reports of sexual abuse or sexual harassment, an internal administrative investigation is immediately initiated by one of the agency's specially trained investigators. The Chief also described how an administrative and criminal investigation would be completed for allegations of sexual abuse or sexual harassment, and he explained that for an administrative investigation, the Chief would assign a trained investigator (such as the PREA Coordinator for the Department) to begin an administrative investigation. The administrative investigator would review applicable surveillance video, collect witness, victim, and alleged perpetrator written statements; interview the victim, perpetrator, and applicable witnesses; complete investigative reports; and follow all additional investigative procedures as prescribed in Policy 12.5. The Chief also advised that the PC would be the agency's liaison and point of contact for the criminal investigation- JCJPD and TJJD.

Lastly, the PC (who is also a specially trained investigator for the agency and Detention Superintendent) explained to the auditor during his interview that during an administrative investigation, he would review and preserve (save) applicable video evidence; document who was involved in the alleged incident; review for any deviations of schedule, interview witness, victims, and the alleged perpetrator (asking a lot of open-ended question); ensure the JCSD and TJJD were notified to conduct the criminal investigations within the required timeframes; and follow all additional investigative procedures as prescribed in agency Policy 12.5.

115.322 (d):
N/A. The auditor is not required to audit this provision; although, it should be noted that this provision language is included in agency Policy 12.5 on page 7.

115.322 (e):
N/A. The auditor is not required to audit this provision; although, it should be noted that this provision language is included in agency Policy 12.5 on page 7.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.331 Employee training

Auditor Overall Determination: Exceeds Standard

Auditor Discussion

115.331

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 12.5 (Sexual Abuse & Mistreatment) / Last updated: 09/02/2016
- Moss Group Training Curriculum (used by the Agency to train staff)
- Training Verification Documentation
- Texas Administrative Code (TAC) Chapter 344
- Staff Roster (to cross-reference with training verifications)

Interviews:

- Random Sample of 12 Staff (JSOs)
- Casework Manager

Site Review Observations:

During the onsite audit, the auditor observed the agency's training room in which was a large room with a TV monitor. The Casework Manager explained that trainings are conducted in the room at least once per month for all Detention staff.

Explanation of determination:

115.331 (a):
Each of the 11 training elements of this PREA provision are included in the agency's PREA training curriculum material provided in the PAQ, titled- PREA Employee Training / Authors: The Moss Group, Inc. Per the PREA Resource Center (PRC) website (https://www.prearesource center.org/library/search?keys=Moss+Group&cat= All), the purpose of this PREA training created by the Moss Group is to assist agencies in addressing training requirements found in PREA standards 115.31, 115.131, 115.231, and 115.331.

The curriculum units and training length are described below, as per the PRC website and as verified by the auditor upon review of the PREA training curriculum the agency provided in the PAQ for this PREA provision:

The curriculum includes six units that total 11.5 hours. It is understood that staff training hours may be restrictive, requiring modification of the curriculum to meet the allotted hours. This training was designed to be as concise as possible while still including meaningful discussion and application of skills. Suggested discussions and exercises should be conducted when possible.
- Unit 1: The Prison Rape Elimination Act: Overview of the Law and Your Role (1.5 hours)
- Unit 2: Inmates' Rights to be Free From Sexual Abuse and Sexual Harassment and Inmates'

Rights to be Free From Retaliation for Reporting (1.5 hours)
- Unit 3.1: Prevention and Detection of Sexual Abuse and Sexual Harassment (2.75 hours)
- Unit 3.2: Response and Reporting of Sexual Abuse and Sexual Harassment (1.75 hours)
(with First Responder Role Play Activity – Facilitator Sheet included)
- Unit 4: Professional Boundaries (1.75 hours)
(with Professional Boundary Scenarios included)
- Unit 5: Effective and Professional Communication With Inmates (2.25 hours)

It was reported by the Casework Manager that the initial and recurring (annual) PREA trainings include the complete Moss Group PREA training detailed above, as well as training all staff on the requirements pursuant to agency Policy 12.4 (Juvenile Grievance Procedures) and 12.5 (Sexual Abuse & Mistreatment). The auditor appreciated the agency including the facility and agency specific guidance provided in the PREA training in order to demonstrate to each employee how the associated PREA protocols should be followed and adhered to in order to maintain a high level of sexual safety.

Additionally, per agency Policy Ch. 12.5 on page 11, all departmental employees will be trained to recognize the physical, behavioral, and emotional signs of sexual abuse. Staff will also be trained to recognize the signs and symptoms of victimization in juveniles and typical predatory methods employed by sexual abusers such as grooming, set-ups, and extortion. The training shall be tailored to the unique needs and attributes of the juveniles referred to MRJJC.

In addition, TAC Chapter 344.620 requires all new county employees seeking certification as a Juvenile Supervision Officer (JSO) to successfully complete of a list of mandatory topics, including PREA, and a competency exam before performing the duties of a certified officer and for certification.

Furthermore, the auditor randomly selected 12 staff to interview from each of the three shifts, and 100% of the staff interviewed stated they have been trained within the past 12 months on all the eleven PREA requirements of this provision. Staff hired within the past 12 months stated that they received PREA training during the JSO basic training (before working the floor), and staff who were hired more than a year 12 months from the date of the onsite stated that they received PREA training in annual PREA refresher trainings. Each staff member interviewed was able to clearly articulate that the training included the agency's zero tolerance policy, procedures for reporting sexual abuse and sexual harassment, how to respond to a sexual abuse or sexual harassment incident, first-responder protocols, investigative protocols for criminal and administrative investigations, how residents can report sexual abuse or sexual harassment, how to immediate respond to a resident who is determined to be at risk of imminent sexual abuse, etc.

115.331 (b):
Per Policy 12.5 on page 11, all departmental employees will be trained to recognize the physical, behavioral, and emotional signs of sexual abuse. Staff will also be trained to recognize the signs and symptoms of victimization in juveniles and typical predatory methods employed by sexual abusers such as grooming, set-ups, and extortion. The training shall be tailored to the unique needs and attributes of the juveniles referred to MRJJC. It should be noted that the auditor confirmed while conducting the onsite audit that the agency only

operates one facility; therefore, an employee would never be transferred from a facility that houses only male residents to a facility that houses only female residents, or vice-versa. Additionally, even though the agency only operates one facility for the housing of male and female residents, the agency advised the auditor that male staff only are assigned to the male PODs and female staff are only assigned to the female POD. This practice was confirmed by the auditor when he conducted the facility inspection, in which only male staff were supervising male residents and only female staff were supervising female residents. Additionally, the auditor analyzed the agency's schedule for the entire month of July 2019, and he was able to verify that each shift included enough male and enough female staff to supervise the same gender residents and stay within the PREA required ratios of 1:8 and 1:16. Furthermore, it should be noted that the agency's PREA training provided (Moss Group PREA Training) to all employees includes a training topic that is tailored to each gender of residents: "Common Responses of Male and Female Victims in Confinement Settings."

115.331 (c):
Agency Policy 12.5 on page 11 explains that all staff receive the PREA training, as described in (a) and (b) of this PREA standard's explanation of determination, before supervising residents (pre-service) and during annual (at least within every 12 months between trainings) PREA training refreshers. The Casework Manager advised the auditor that the training material is the same for the initial PREA training and the annual refreshers. The agency was able to provide the auditor with training verification forms for each current staff member, as described in more detail below, in (d).

115.331 (d):
Policy 12.5 on page 12 states that the agency shall maintain documentation that the employee understands the training that they have received. This was verified by the auditor upon a detailed review of each training verification form and training sign-in sheet. The agency provided the auditor with a current staff (JSO) roster of 27 names of JSOs who currently work in the Detention Center (as of 7/10/2019), and the auditor was able to verify that each staff member listed on this roster had received the required PREA training (either as an initial training for staff hired within the past 12 months or through a refresher training). The training verification documents included sign-in sheets for "Detention PREA Training and Policies 12.4 and 12.5" and "PREA Training Acknowledgement/Duty to Report Allegations of Abuse, Neglect, Exploitation and Sexual Abuse and Sexual Harassment" signed forms by each staff member. The PREA Training Acknowledgement forms include a detailed explanation of the training that was covered including, but not limited to:
- the agency zero-tolerance policy of any sexual abuse and sexual harassment between employees, teachers, contractors, and volunteers and the juveniles that are under the jurisdiction of the Department;
- the requirement to report any allegations of abuse, neglect, and exploitation (to include sexual abuse and sexual harassment);
- the consequence for failing to report;
- the requirement to cooperate fully with any type of internal investigation; and
- the eleven elements of the training topics pursuant to PREA standard §115.331 (a) (1-11).

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency substantially exceeds all elements of this standard. No corrective action is

required.

115.332 Volunteer and contractor training

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.332

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 12.5 (Sexual Abuse & Misconduct) / Last updated: 09/02/2016
- Memo from the PREA Coordinator (PC) covering Volunteer and Intern training curriculum
- Volunteer List (including 21 total volunteers names)
- Contractor List (including a list of names for 4 medical contractors and 12 teachers, for a total of 16 contractors)
- PREA Training Acknowledgement / Duty to Report Allegations of Abuse, Neglect, Exploitation and Sexual Abuse and Sexual Harassment forms

Interviews:

- Volunteers who have Contact with Residents
- Contractors who have Contact with Residents

Site Review Observations:
During the onsite facility inspection by the auditor with the PREA Coordinator (Detention Superintendent), the auditor observed the educational classrooms, which were empty while the auditor was onsite (no residents or educational staff observed in this area by the auditor). It was explained by the PC that the MRJJC contracts with the Beaumont Independent School District (BISD) for state certified teachers, and they follow the same regular school calendar as the BISD; therefore, since it was summer time (June), no school was in session and no teachers were in the facility.

Explanation of determination:

115.332 (a), (b), and (c):
Agency Policy 12.5 on page 12 outlines that the department's requirements to adhere to the PREA provisions of this standard, and states that the MRJJC shall ensure that all volunteers and contractors who have contact with juveniles have been trained on their responsibilities under the department's sexual abuse and sexual harassment prevention, detection, and response policies and procedures. It should be noted that Policy 12.5 specifically states that all volunteers and contractors who have contact with juveniles shall be notified of the department's zero tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents. The department is required to maintain documentation confirming that volunteers and contractors understand the training that they received, per 12.5.

The PREA Coordinator (PC) and Casework Manager advised that the PREA material covered in training refreshers for contractors, volunteers, and interns is the same PREA training

refresher that all JCJPD employees receive (Moss Group Training as described in §115.331), and in addition, the training also includes covering agency Policy 12.5 in its entirety. The auditor was able to cross-reference 21 volunteer PREA Training Acknowledgement forms with the provided volunteer list of names for 21 total volunteers with the MRJJC. The auditor confirmed that 100% of the volunteers have received the required PREA training and understood the training they received, and that this training was provided annually for each volunteer. The PREA Training Acknowledgement forms include, at a minimum, the required training topics of this PREA provision. Additionally, the agency provided the auditor with a list of all the contracted teachers with the BISD that teach during the school year in the MRJJC, which included 12 names. This list was cross-referenced with the PREA Acknowledgement Training forms provided to the auditor, and all 12 (100%) of the teachers signed the form acknowledging the PREA training they received. It was explained to the auditor that each teacher receives this PREA training every summer before the school year begins, and it should be noted that the agency provided the auditor with an annual PREA training acknowledgement form for each teacher dated 8/13/19 (before 2019 school year began). Furthermore, the agency provided a list of medical contractors the agency contracts with- a total of four (4), two nurses and two Doctors. The agency provided the auditor with a PREA training acknowledgement form for each medical contractor, and the agency demonstrated to the auditor, through multiple years of PREA acknowledgement forms, that the PREA training is provided to each medical contractor annually. To recap the number of contractors and volunteers, it should be noted that the agency reported in the PAQ that they had a total of 51; although, after clarification from the PC and Casework Manager, it was determined that the actual number of contractors and volunteers was 37. The agency provided a list of names for each contractor and volunteer that included 37 names and a brief of each contractor's role for the MRJJC. Below is a breakdown of the number of contractors and volunteers:
- 12 teachers with BISD;
- 4 medical contractors (2 Doctors & 2 nurses); and
- 21 volunteers.
- Totaling: 37

Additionally, the auditor interviewed two volunteers from the Grandparents Fostering Program, who advised that they receive PREA training annually through their organization and through the MRJJC. Each of the volunteers were able to clearly explain that they were trained and understand their responsibilities regarding sexual abuse and sexual harassment prevention, detection, and response, per agency policy and procedure. In addition, the two volunteers described that they received facility specific training related to the agency's zero tolerance policy on sexual abuse and sexual harassment (Policy 12.5), as well as informed about how to report such incidents. The auditor asked each volunteer how they would report an outcry of sexual abuse or sexual harassment made by a resident, and each volunteer explained how they would ensure the alleged victim is safe and immediately notify a supervisor or the Detention Superintendent. Additionally, each volunteer was aware of their responsibilities of reporting any sexual abuse to law enforcement.

One of the contracted nurses was interviewed by the auditor, and she explained that she receives PREA training annually. The nurse described that the training included contractor's responsibilities of reporting sexual abuse and sexual harassment, as well as the agency's zero-tolerance policy regarding sexual abuse and sexual harassment (Policy 12.5). She was aware of the TJJD reporting Hotline number (a phone reporting system in place for residents,

staff, or anyone else to report to an outside agency- TJJD- of any type of abuse or harassment). The nurse advised the auditor that if a resident from the MRJJC made an outcry of abuse to her, she would immediately notify the PREA Coordinator and call the TJJD Hotline. She also explained some of the first-responder protocols that she was trained to adhere to if a resident reports being a victim of sexual abuse, such as: ensure the safety of the victim, advise the victim to not shower or doing anything that may destroy physical evidence, and monitor the victim until law enforcement arrives. Lastly, the nurse explained that she would be able to provide emergency medical care if needed, and that a resident victim of sexual abuse would be transferred to a hospital for further assessment and examination.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.333 Resident education

Auditor Overall Determination: Exceeds Standard

Auditor Discussion

115.333

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 16.2 (Admission Procedures) / Last updated: 06/16/2016
- Detention Handbook (Spanish & English versions)
- Orientation & Handbook Receipt
- PREA Orientation form (update- changed name to “Comprehensive PREA Orientation)
- Email Communication from Abshire Interpreting
- Digital pictures of PREA related posters posted throughout the facility.

Interviews:

- Intake Staff
- Randomly Selected Residents

Site Review Observations:

During the onsite audit, the auditor observed Resident Handbooks in the resident rooms he inspected.

Explanation of determination:

115.333 (a):
Agency Policy 16.2 on page 4 explains that during the intake process, juveniles shall receive information explaining, in an age appropriate fashion, the department’s zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment. Policy 16.2 also states that upon completion of the orientation process, each juvenile shall be provided a written copy of the orientation material- to include a Resident Handbook- and sign and date a statement confirming that orientation has been provided. This statement is titled, “Orientation and Handbook Receipt,” which is described in 16.2 to be placed in the juvenile’s records. The orientation process is explained in Policy 16.2 to include a review of the Resident Handbook, which on pages 15-17 of the Handbook outlines the PREA information that is required to be provided to each resident during the initial intake process (orientation) and the comprehensive PREA education that is described later in this PREA standard. The agency’s zero-tolerance statement and information related to how to report incidents or suspicion of sexual abuse or sexual harassment is documented in the Resident Handbook and on the Orientation and Handbook Receipt form. Upon review of the PREA information included in the Resident Handbook, the auditor determined that the information is described in an age appropriate fashion that is easy to read and follow.

The agency documented in the corresponding section in the PAQ that the MRJJC admitted 331 residents in the past 12 months, and all 331 were provided the PREA orientation material pursuant to this PREA provision.

In order to verify the requirements of this PREA provision are fully implemented in practice at the MRJJC, the auditor selected nine (9) randomly selected resident files to ensure the files included the facility's "Orientation and Handbook Receipt" for each of the nine residents. Upon review of each of the files, 100% (all 9) of the files included a signed Orientation and Handbook Receipt form (signed and dated by the resident and staff member conducting the intake). Furthermore, it should be noted that each of the forms were dated with the same date of the resident's admission into the facility, and that the practice explained to the auditor by the intake staff member interviewed while onsite, clarified that each intake process is completed within 2 to 3 hours from the time the resident is first admitted into the facility.

The intake staff member interviewed by the auditor also explained that she reads the Resident Handbook to each resident admitted into the facility, and that this includes explaining to each resident the agency's zero-tolerance policy and reporting protocols.

Additionally, eleven randomly selected residents were interviewed by the auditor (out of a total population of 13 / 85%) and asked questions related to the PREA information provided during their intake process, and each of the eleven residents were able to confirm in their own words that the Handbook was reviewed with them within a few hours of being detained (admitted into the facility). Additionally, residents advised the auditor that the Handbook is reviewed with each resident on Mondays, Wednesdays, and Fridays by staff, and that the resident Handbooks can be kept in their rooms. Although, some of the female residents advised that they elect not to keep their Handbook in their room because they don't want too many things in their room. The auditor followed up and asked if the Handbook is not kept in the room, then where is it kept? The residents advised that they keep their Handbook on the POD. Each resident was clearly aware of the agency's zero-tolerance policy of sexual abuse and sexual harassment and could explain multiple systems for reporting sexual abuse or sexual harassment.

115.333 (b):
Policy 16.2 on page 4 outlines the agency's requirement to provide comprehensive age-appropriate education to juveniles, within 10 days of intake, either in person or through video regarding their rights to be free from sexual abuse and sexual harassment, to be free from retaliation for reporting such incidents, and regarding department policies and procedures for responding to such incidents. Additionally, 16.2 states that the verbal orientation (that includes PREA orientation information) will take place at the time of the intake but no later than 12 hours from the time of admission. The department shall maintain documentation of juvenile participation in these education sessions, per 16.2. The MRJJC provided the auditor with their, originally titled, "PREA Orientation" form. This form includes the juvenile's name, room number, initial Orientation Date and time for PREA information received during the intake process, the date and time for this comprehensive PREA education, four check boxes for residents to acknowledge the PREA material provided (to include the PREA video, Handbook, Victim Advocacy information, and the TJJD Hotline Procedures), a space for a resident to sign an acknowledgement statement, and a line for the JSO presenting the comprehensive information to sign and print their name. The auditor recommended the agency revise the title

of this form so that it is not confused with the initial PREA orientation that is provided during the intake process; the auditor recommended the title be changed to “Comprehensive PREA Orientation.” It should be noted that this was ONLY a recommendation for enhancement by the auditor, and the agency accepted and fully implemented the recommendation. The current name of the form is: “Comprehensive PREA Orientation.” Additionally, it should be noted that the agency operates one facility (as verified by the auditor onsite), MRJJC, and all residents admitted into the facility, regardless of transfer or a new referral, are processed through intake and provided the required PREA education in the same format. This was also described by the agency in this subsection of the PAQ {115.333 (c)-4}.

The agency’s comprehensive PREA education is provided to the residents from two sources, the Resident Handbook (pages 15-17) and a 27 minute PREA video produced by the Texas Juvenile Justice Department. Both sources are available to residents in Spanish and English versions, and this was verified by the auditor. The first method of provided comprehensive PREA education is through the review of the Handbook. The auditor reviewed the three pages of PREA information from the Handbook, and the auditor was able to determine that the information is comprehensive and written in an age-appropriate fashion. The second method providing comprehensive PREA education is through a PREA video produced by the TJJD. This video was watched by the auditor while onsite, and the video covered all the requirements of this PREA standard. The video included juvenile actors, as well as professional staff, who provided a comprehensive, all-inclusive, and age-appropriate education that included, but is not limited to, the following topics:

- What it’s really like (being detained)
- Understanding Your Rights (14 basic rights)
- Zero Means Zero (safety, zero-tolerance, bullying, sexual misconduct, sexual abuse, and sexual harassment- explained by both juveniles and staff
- Tips for Staying Safe (grooming examples and meaning, testing the limits, favors, personal space, contraband, sharing of personal info, extortion, how to dispatch help, removing the victim or perpetrator, special programs, safe environment, not being afraid to report, etc.)
- Making Reports (Don’t be afraid, report, responsive, Hotline phone, grievance procedures, telling an adult the resident trusts, investigation process and timelines, speak up, etc.)
- Safety for Girls (red flags, zero-tolerance, emotional attachment, physical touch, don’t get involved in girl relationships, focus on individual goals, etc.)
- Conclusion (safety is the foremost important thing, treat others with dignity and respect, follow-rules, know boundaries, etc.).

It should be noted that the TJJD PREA video is available online, at the following address: https://www.youtube.com/watch?v=kEFgjDvzBRc

In order to confirm that the agency practices their procedures for providing the requirements of this PREA provision, the auditor selected nine (9) randomly selected resident files to ensure the files included the facility’s “Comprehensive PREA Orientation” form for each of the nine residents. Upon review of each of the files, 100% (all 9) of the files included a signed Comprehensive PREA Orientation form (signed and dated by the resident and staff member conducting the intake), and each of the signed forms were completed within the required 10 days of each resident’s admission date. It should be noted that the agency exceeded the 10 day minimum requirement by at least 7 days for each of the PREA forms reviewed by the

auditor (*with 3 days being the longest length of time between the day the resident was admitted into the facility and when the comprehensive PREA was provided). Furthermore, the auditor also reviewed an additional eight randomly selected Comprehensive PREA Orientation forms provided to the auditor before the onsite, and each of those forms were also in compliance with the 10 day requirement of this provision.

Additionally, the agency exceeds this PREA provision by providing the comprehensive PREA education monthly for each resident. The auditor was advised by the PC, Casework Manager, and the Intake Officer that the facility provides the comprehensive PREA education to each resident monthly, and this practice is documented on the same form as the initial comprehensive education- the “Comprehensive PREA Orientation” form. The auditor verified this practice by reviewing the nine (9) resident files and discovered that there were additional Comprehensive PREA Orientation forms for each applicable resident whose length of stay was 30 days or longer. For example, two residents, whose length of stay were approximately three months, each had three Comprehensive PREA Orientation forms (one for each month the resident was detained). Furthermore, 100% of the residents whose length of stay was over 30 days or more, their files included a completed PREA Comprehensive Orientation form for each month detained.

The auditor interviewed an intake staff member who advised that the agency provides each resident with comprehensive PREA education by reading the Handbook with the residents and having the residents watch the PREA video within approximately 24 to 48 hours after a child is first admitted into the facility. She explained that residents sign an acknowledgement form that indicates they have received and understand the PREA information provided.

115.333 (c):
The agency operates one facility (as verified by the auditor onsite), and all residents admitted into the facility, regardless of transfer or a new referral, are processed through intake and provided the required comprehensive PREA education as outlined in subsection (b) of this PREA standard explanation of determination. This was also described by the agency in this subsection of the PAQ {115.333 (c)-4}.

115.333 (d):
Policy 16.2 on page 4 states that the department shall provide juvenile education in formats accessible to all juveniles, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to juveniles who have limited reading skills.
If a language barrier exists, a juvenile shall receive written orientation material in his/her own language within the first 48 hours. If a literacy problems exists, a staff member will assist the juvenile in understanding the material within the first 48 hours. This Policy also explains that each juvenile shall be provided a written copy of the orientation materials.

The agency provided the auditor with a Spanish and English version of their Resident Handbook and Resident PREA Orientation video. Additionally, the auditor reached out to the interpreting service used by the Agency, Abshire Interpreting Services, and the auditor verified the services that Abshire Interpreting can provide to a resident of the MRJJC are sufficient to the requirements of this PREA provision. An affiliate from Abshire also explained to the auditor that the interpreting services are available 24/7 to the agency.

115.333 (e):
Policy 16.2 on page 4 states that the department shall maintain documentation of juvenile participation in these education sessions, pursuant to PREA standard 115.333.

In order to confirm that the agency practices their procedures for providing the requirements of this PREA provision, the auditor selected nine (9) randomly selected resident files to ensure the files included the facility's "Orientation and Handbook Receipt" form and their "Comprehensive PREA Orientation" form for each of the nine residents. Upon review of the files, 100% (all 9) of the files included the required forms and each was signed and dated by the resident and staff member conducting the intake. Furthermore, the auditor also reviewed an additional eight randomly selected Comprehensive PREA Orientation forms provided before the onsite, and all eight of these forms were completed and adequately demonstrated that the agency maintains documentation of resident participation in PREA education sessions.

The auditor interviewed an intake staff member who advised that residents sign an acknowledgement form that indicates they have received and understand the PREA information provided.

115.333 (f):
Policy 16.2 on page 4 outlines the requirements of this provision by ensuring residents are provided the required PREA education and information through posters, the Resident Handbook, and other written forms (i.e., Orientation and Handbook Receipt). The agency provided the auditor before the onsite ten (10) digital pictures of all the PREA related posters posted throughout the facility. The posters were titled, "End the Silence," and they were available in Spanish and English. During the onsite visit, the auditor verified that the posters included key information related to this PREA standard and that they were visible to residents throughout the facility. It should be noted that the agency also posted these posters in their visitation waiting area for the public to view.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency substantially exceeds all elements of this standard. No corrective action is required.

115.334 Specialized training: Investigations

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.334

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 15.12 (Notification and Reporting Illness, and Investigating Abuse, Exploitation or Death) / Last updated: 06/16/2016
- Specialized Investigator Training Certificates
- Bureau of Prisons National Institute of Corrections Training Curriculum

Interviews:

- Investigative Staff

Explanation of determination:

115.334 (a) – (c):
Policy 15.12 on page 3 states that the Chief Probation Officer (Director of JCJPD), Juvenile Casework Manager, Detention Superintendent (PREA Coordinator), and two Detention Casework Supervisors are authorized to conduct sexual abuse investigations and shall receive training in conducting such investigations in confinement settings. The Policy also states that specialized training shall include 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. Additionally, 15.12 on page 3 states that the department shall maintain documentation that department investigators have completed the required specialized training in conducting sexual abuse investigations.

The agency provided the auditor with Department of Justice Certification of Completion documents for each of the agency administrative investigators and the corresponding curriculum from the training. The Certificates state that each investigator was trained on "PREA: Investigating Sexual Abuse in a Confinement Setting," and that the training was presented by the National Institute of Corrections (3 hour training). The training curriculum provided breaks down the training into three (3) chapters with multiple sections in each chapter, including the following training topics:
- Taking the Course, General Investigative Protocols, The Allegation, Initial Response, Evidence Collection and Preservation, Interviews and Interrogations, Non-Witness Interviews, Review of Past Reports and Records, and Determination of Findings.

The auditor interviewed the Detention Superintendent, who is also the PREA Coordinator (PC) and an administrative investigator for the agency, and he explained that he has completed two different investigative trainings- one with TJJD and one online with the Department of Justice

(as described above). The PC explained his responsibilities for conducting an administrative investigation to include: ensuring the victim is safe and separated from the perpetrator; preserving video evidence; document who was involved; investigate for any deviations to schedule; review log books and other related documentation; interview witnesses, victim, and perpetrator (asking open-ended questions as applicable); ensure the JCSD and TJJD has been contacted; and cooperate and remained informed with the criminal investigation. The PC was able to clearly articulate the training materials provided during the two trainings he completed, to include the investigative protocols as described above, techniques for interviewing juvenile sexual abuse victims, the 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 (preponderance of evidence for administrative investigations).

115.334 (d):
N/A. The auditor is not required to audit this provision.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.335 Specialized training: Medical and mental health care

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.335

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 12.5 (Sexual Abuse & Mistreatment) / Last updated: 09/02/2016
- Department of Justice (DOJ) Certificates of PREA Trainings for the two contracted nurses and for the agency's Mental Health Provider (MHP) / Presented by the National Institute of Corrections (NIC)
- NIC's website
- Memo from PC regarding PREA training for volunteers and contractors
- PREA Training Acknowledgement / Duty to Report Allegations of Abuse, Neglect, Exploitation and Sexual Abuse and Sexual Harassment" forms signed by the two contracted nurses and the one MHP for the agency

Interviews:

- Medical Health Staff
- Mental Health Staff

Explanation of determination:

115.335 (a) – (d):
Agency Policy 12.5 outlines that the department (JCJPD) shall ensure that all full and part-time medical and mental health care practitioners (including contracted nurses) who work regularly in its facilities have been trained in:

- 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 victims of sexual abuse and sexual harassment; and
- How and to whom to report allegations or suspicions of sexual abuse and sexual harassment.

The agency reported in this provision section in the PAQ {115.335 (a)- 2 and 3} that they had three (3) medical and mental health care practitioners who work regularly at the facility who received the training required by agency policy and that all three (100%) received the training. The auditor learned that the agency utilizes one fulltime MHP and two contracted nurses, and each practitioner works regularly in the MRJJC. The auditor verified that all three practitioners completed the required training by reviewing the Department of Justice Certificates of Completion and agency specific "PREA Training Acknowledgement / Duty to Report Allegations of Abuse, Neglect, Exploitation and Sexual Abuse and Sexual Harassment" forms

for each medical and mental health staff. The Department of Justice Certificates included documentation that the training was provided by the National Institute of Corrections on PREA, specifically- Medical Health Care for Sexual Assault Victims in a Confinement Setting (3 hour course). Additionally, PREA Training Acknowledgement forms included a review of Policies 12.4 and 12.5, as indicated by the PC in a signed memo to the auditor.

The PREA Training Acknowledgement forms include a detailed explanation of the training that was covered including, but not limited to:
- the agency zero-tolerance policy of any sexual abuse and sexual harassment between employees, teachers, contractors, and volunteers and the juveniles that are under the jurisdiction of the Department;
- the requirement to report any allegations of abuse, neglect, and exploitation (to include sexual abuse and sexual harassment);
- the consequence for failing to report;
- the requirement to cooperate fully with any type of internal investigation; and
- the eleven elements of the training topics pursuant to PREA standard §115.331 (a) (1-11).

Upon review of the DOJ training curriculum and agency specific PREA training provided to each of the contracted medical staff and the fulltime MHP, the auditor determined that the trainings include, at a minimum, the level of training provided for all employees under §115.331 and for contractors and volunteers under §115.332. Additionally, the auditor reviewed the NIC's website in order to ensure the training material presented in the contracted nurses and MHPs NIC PREA training is in compliance with the requirements of §115.335, and it should be noted that the NIC's website states: "The main purpose of this course is to assist agencies in meeting the requirements of Prison Rape Elimination Act (PREA) standard 115.335 "Specialized Training: Medical and Mental Health Care". At the end of this course, you'll be able to explain the knowledge, components, and considerations that you must use to be effective in your role as a behavioral health care practitioner, consistent with PREA standards." Furthermore, NIC's website explains that the PREA training includes courses for medical and mental health practitioners that include:
- Behavioral Health Care for Sexual Assault Victims in a Confinement Setting- which will assist agencies in meeting the requirements of PREA standard 115.335; and
- Medical Health Care for Sexual Assault Victims in a Confinement Setting" which will assist agencies in meeting the requirements of PREA Section 115.335.

One of the contracted nurses was interviewed by the auditor, and she explained that she receives PREA training annually. The nurse described that the training included contractor's responsibilities of reporting sexual abuse and sexual harassment, as well as the agency's zero-tolerance policy regarding sexual abuse and sexual harassment (Policy 12.5). She was aware of the TJJD reporting Hotline number (a phone reporting system in place for residents, staff, or anyone else to report to an outside agency- TJJD- of any type of abuse or harassment). The nurse advised the auditor that if a resident from the MRJJC made an outcry of abuse to her, she would immediately notify the PREA Coordinator and call the TJJD Hotline. She also explained some of the first-responder protocols that she was trained to adhere to if a resident reports being a victim of sexual abuse, such as: ensure the safety of the victim, advise the victim to not shower or doing anything that may destroy physical evidence, and monitor the victim until law enforcement arrives.

Additionally, the auditor also interviewed the agency's fulltime Mental Health Provider (MHP) who explained that she is a licensed Sex Offender Treatment Provider (LSOTP) and licensed Professional Counselor (LPC). The MHP explained in her interview that she also has received certifications as a Forensic Counselor, Clinical Certified Domestic Violence Counselor, Master Addiction Counselor, and Anger Resolution Therapist. The MHP advised the auditor that she is currently in her second year of her Doctoral program in psychology, and that she completes recurring training every year related to juvenile management of sex offenders (24 hours a year) and agency specific PREA training, as verified by the auditor and explained above.

The agency reported in the corresponding PAQ question that they do NOT have medical staff in at the facility who conduct forensic medical exams and this was verified by the auditor when onsite through specialized staff interviews. Additionally, it should be noted that the agency includes the requirement of this PREA provision in agency Policy 12.5 on page 12, to include the following statement, "if medical staff employed by the department conduct forensic examinations, such medical staff shall receive the appropriate training to conduct such examinations."

The MHP and contracted nurse who were interviewed by the auditor explained that agency medical staff do not conduct forensic medical exams, and the contracted nurse explained further that if such an exam were necessary, the child would be referred to Baptist or Christus St. Elizabeth Hospital.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.341 Obtaining information from residents

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.341

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 16.2 (Admissions Procedures) / Last updated: 06/16/2016
- Facility Intake Behavioral Screening form (initial and applicable periodic reassessments)
- Texas Administrative Code 343.414 (Behavioral Screening)
- Resident Detention Files (9 files out of the available 13 of residents currently in detention at the time of the onsite- 70%)
- Intake Assessment and Re-Assessment Dates Every 30 Days (Spreadsheet)

Interviews:

- Intake Staff Responsible for Risk Screenings
- 11 Randomly Selected Residents
- PREA Coordinator (PC)

Site Review Observations:

During the onsite audit, the auditor was advised by the PREA Coordinator (PC) that they currently had one resident who was identified by the Behavioral Screening to be a victim of prior sexual abuse that occurred in the community, and that no other targeted residents are currently in the detention population. This was also verified by the auditor through interviewing 11 out of the total detention population of 13 residents during the onsite, with the one resident stating she had been a victim of sexual assault while in the community.

Explanation of determination:

115.341 (a):
Agency Policy 16.2 on pages 1-2 outline the classification and behavioral screening process of all juveniles admitted into the facility (including all transfers), and the behavioral screening process is explained to screen for each resident's risk of sexual abuse victimization and sexual abusiveness toward other residents. This is processed through the use of the Agency's Behavioral Screening form that is used as their risk assessment. Policy 16.2 explains that the information gathered during the intake process for the behavioral screen should be ascertained through conversations with the juvenile during the intake process and medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records, and other relevant documents from the juvenile's file. Additionally, Policy 16.2 on page 2 requires that residents be screened for risk of sexual victimization and risk of sexually abusing other residents within 72 hours of their intake and periodically (monthly) throughout the juveniles' confinement.

The agency indicated in the PAQ that out of the 262 residents who entered the facility in the past 12 months whose length of stay was 72 hours or more, all 262 (100%) were screened for risk of sexual victimization and for risk of abusing other residents within 72 hours of their entry into the facility.

The auditor verified the agency's practice of the requirements of this provision by reviewing resident detention files of 9 out of the total resident population of 13 (70% of the population) and analyzing the initial and periodic Behavioral Screening forms in each file. Each of the 9 resident files reviewed indicated that the initial Behavioral Screen was completed for each resident on the same date of their admission into the facility- substantially exceeding the requirement of this provision to complete such a screening within 72 hours. It was reported to the Auditor that the Behavioral Screen is completed within a few hours of each child being admitted. Additionally, 7 of the 9 files reviewed by the auditor included a periodic risk reassessment, a subsequent Behavioral Screening form, which indicated the reassessment was completed at least every 30 days for each applicable resident (*with the average amount of days between reassessments being 26.5 days, as calculated by the auditor). The two resident files that were missing periodic reassessment forms did not require the reassessment due to the residents not yet reaching 30 days in detention. The analysis of the resident files by the auditor sufficiently demonstrates that the facility conducts the required risk screenings within 72 hours of intake and periodically throughout each resident's confinement to reduce the risk of sexual abuse by or upon a resident.

Additionally, the Casework Manager provided the auditor with detailed procedures for how the facility tracks residents who are due for the reassessment, and the procedures include:

- The Control Room Operator maintains a spreadsheet (described below) with the reassessment flag date and it is updated until the juvenile is released.
- Each reassessment form is reviewed by a Detention Supervisor, the PREA Coordinator, and the agency's Mental Health Practitioner (MHP).

The agency provided the auditor with their "Intake Assessment and Re-Assessment Dates Every 30 Days" spreadsheet that is utilized by the Control Room to ensure the initial Behavioral Screen ("Intake Assessment/Risk Assessment") is completed within 72 hours of each resident's admission and that the Behavioral Screen reassessment (periodic risk reassessment) is completed every 30 days for each applicable resident. The spreadsheet documents each resident who is currently in detention, their intake assessment date, reassessment flag date (due by), completed reassessment date, and applicable continued reassessment flag dates and completed dates (for residents whose length of stay requires multiple 30 day reassessments). Upon analysis of the spreadsheet by the auditor, it should be noted that the spreadsheet documents 18 residents, the dates for the initial Behavioral Screen (initial risk screening) for each of the 18 residents, and the dates for the periodic reassessments. The auditor determined that the spreadsheet is a good tool for maintaining documentation of when the initial risk screening was completed, when the applicable reassessments are due, and when the reassessments were actually completed. Out of the 18 residents listed on the spreadsheet provided to the auditor, all 18 entries (100%) reflect that the initial risks screening was completed the same day as when they were admitted (within 72 hours) and the reassessments were completed every 30 days (monthly) for each applicable resident.

Furthermore, the auditor interviewed a staff member who is responsible for working intake and conducting resident risk screenings. This officer advised the auditor that the facility utilizes their Behavioral Screening (risk screening) form to screen residents upon their admission into the facility for risk of sexual abuse victimization and sexual abusiveness toward other residents. She explained how the screening is conducted within a few hours of the juvenile being admitted and before the resident is assigned a classification (housing area/room), and that the screening is conducted in a private and confidential setting. The intake officer described how the MHP is notified and assesses each child, regardless of the risk screening results, within one or two days of being admitted. It was explained that if the MHP is not available (not in the building), the MHP is contacted over the phone and follows up with the child within a day or two. This officer discussed how the only people who have access to the residents Behavioral Screen are the Detention Supervisors, Superintendent, assigned Juvenile Probation Officer (JPO), Child Protective Services and Law Enforcement (if applicable in certain situations dealing with an abuse allegation), and the agency's MHP. The intake officer also explained that the MHP has a face-to-face meeting with every resident admitted into the facility, regardless of the results of the Behavioral Screening, within a day or two of each resident's admission into the facility. If a resident's Behavioral Screening indicates that the child is at risk of being victimized or abusing another resident, this officer advised that she would immediately notify the Superintendent, Casework Manager, and a Detention Supervisor to await further instructions. The intake officer was also asked by the auditor how often resident's risk levels are reassessed in the facility, and she advised that she is one of the staff in charge of ensuring the reassessments are completed. She described how the Central Control Officer will let her know which resident/s are due for the periodic reassessment by reviewing each resident's length of stay, and the intake officer will then ensure the reassessments are completed within every 30 days (monthly) for each applicable resident.

The Casework Manager reported to the Auditor that all JSO certified staff (27 total) are trained by a Supervisor in how to conduct a full resident intake during JSO Basic training when they first start their employment, as well as during annual refresher trainings that are conducted monthly. JSOs are trained to use the information disclosed during the intake process to make the best placement decision possible, and the Lead Supervising Officer (LSO) oversees this assignment. The LSO's reviews and signs each Behavioral Screen to make sure that the assignment is most appropriate for the safety and security of all the juveniles within the facility. This was also verified by the Auditor when onsite through his analysis of 9 out of the 13 Behavioral Screening forms reviewed- each form included the Supervisor's signature and the date of review.

In addition to staff interviews, the auditor also randomly selected and interviewed 85% of the total resident population (11 out of 13 available residents) to ensure each resident was screened as related to the requirements of this provision, and every resident interviewed remembered screening questions related PREA Standard 115.341. Some residents even provided more detail in their responses, stating that the questions were asked during the intake process when they first were detained and about every thirty days for resident's whose length of stay was 30 days or longer. One resident whose length of stay was over thirty days stated that the reassessment was completed by a supervisor the day prior, and another resident whose length of stay was approximately 4 months stated that the periodic reassessment is done every month by a supervisor.

Furthermore, it should be noted that TAC 343.414 requires the agency to screen all residents, prior to placing into a housing unit, for potential vulnerabilities or tendencies of acting out with sexually aggressive or assaultive behavior, and that housing assignments shall be made accordingly. The Texas Juvenile Justice Department monitors each juvenile detention center in Texas annually for compliance with this TAC Standard and all other related TAC Standards.

115.341 (b):
The agency provided in the PAQ an objective screening tool, the agency's Behavioral Screening form, that is used for the initial screening and periodic reassessment requirements of this PREA Standard. The form requires staff who are conducting the risk assessment (Behavioral Screen) to document answers to the following set of standard questions:

- Age, Date of Birth, Height, and Weight?
- Current Charge and Offense History?
- Current State of Mind: Calm, Anxious, Angry/Agitated, Depressed, Silly/Giddy, Disoriented/Odd, or Tearful?
- Sexual Orientation?
- Prior sexual victimization or abuse (including perpetrator of sexual aggression or victim of sexual abuse)?
- Level of emotional and cognitive development.
- Physical disabilities?
- Mental, intellectual, or developmental disabilities?
- Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the juvenile may be vulnerable to sexual abuse?
- Does the juvenile have a perception of vulnerability?
- Any other specific information about individual juveniles that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other juveniles, or any other pertinent information?

The agency noted in the PAQ that all PREA risk screening assessments are conducted using an objective screening instrument, and it was apparent that the agency used their objective Behavioral Screening form for all initial risk screenings and applicable reassessments for each of the 9 resident files examined by the auditor during the onsite. The Agency's Behavioral Screen form includes a section on the bottom of the form that requires the staff member conducting the risk assessment to sign and document the date and time the risk assessment was completed. Upon the Auditor's review of each resident's initial Behavioral Screen, each risk screening was documented to have been completed on the same date of the applicable resident being admitted. Furthermore, each of the periodic risk assessments reviewed by the Auditor documented that they were completed monthly for each applicable resident.

Additionally, the intake officer who conducts risk screening advised that all Behavioral Screens are reviewed by a Detention Supervisor, PREA Coordinator, and the agency's MHP. This was also verified by the auditor when he reviewed the 9 resident detention files that included completed Behavioral Screens that were approved by a Detention Supervisor or the Superintendent.

115.341 (c):

Agency Policy 16.2 on page 1 outlines the 11 required elements of this provision {as noted above in 115.341 (b)}, plus additional factors that are considered during the intake process to reduce the risk of sexual victimization or abuse, such as:

- special considerations made for juveniles who are mentally or emotionally disturbed, intellectually challenged, handicapped, abused, or have other unusual conditions such as vulnerabilities or tendencies of acting out with sexually aggressive or assaultive behavior.

Additionally, the Behavioral Screening form was reviewed by the auditor and includes all the requirements of this provision {as noted above in 115.341 (b)}. The Behavioral Screening form includes sections for staff to write in follow-up information, such as:

- Current state of mind (calm, anxious, angry/agitated, depressed, silly/giddy, disoriented/odd, or tearful) with a line for comments from staff on what they observe
- If a victim or perpetrator of sexual abuse, space for staff to explain and indicate the source of where the information was ascertained from (e.g., MAYSI-2 responses, parent report, records).
- The actual level of emotional and cognitive development- typical for chronological age, seems younger than chronological age, and seems older than chronological age.
- Type of physical disability and any known limitations in functioning.
- Source of information if applicable disability (e.g., direct observation, parent report, records).
- Section for staff to explain in more detail information related to a resident who staff identify as having any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the juvenile may be vulnerable to sexual abuse.
- Section for staff to add information related the juvenile's own perception of vulnerability.
- Section for staff to document any other pertinent information.

Furthermore, the auditor interviewed an intake officer who conducts risk screenings of residents admitted into the facility and reassessments, as applicable, and she advised that the agency's Behavioral Screening form consists of, but not limited to, questions that are used to ascertain information about the juvenile's sexual orientation, if the child is a victim or perpetrator of sexual abuse, physical stature of the juvenile, and if the child may be vulnerable to being a victim or perpetrator of sexual abuse.

115.341 (d):
Agency Policy 16.2 on page 1 describes the requirement of this provision and states, "the information gathered should be ascertained through conversations with the juvenile during the intake process and medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's file.

The auditor interviewed the intake staff member who conducts risk screenings, and she advised that the information for the Behavioral Screening is ascertained through a private and confidential conversation with the resident during the intake process. This intake process also includes the intake officer conducting a mental health assessment (MAYSI-2), health assessment/screening, and other intake related responsibilities that aids the intake officer with completing the Behavioral Screening. The MAYSI-2 is the Massachusetts Youth Screening

Instrument that is a brief screening instrument (52 questions) designed to identify potential mental health needs of adolescents involved in the juvenile justice system, and the Agency's health assessment process includes the following requirements (per TAC 343.406):

Health Screening Instrument.
The health screening instrument shall be approved by an RN, nurse practitioner, physician assistant, or physician and shall include:
- mental health conditions and treatment, including any hospitalizations;
- observation of the following:
- general appearance, such as sweating, tremors, anxious, disheveled, or appropriate;
- behavior, such as disorderly, erratic, or appropriate;
- state of consciousness, such as alert, responsive, or lethargic;
- ease of movement, such as ability to walk and move limbs, gait, and bodily deformities;
- breathing, such as persistent cough, hyperventilation, or normal; and
- skin condition, such as lesions, swelling, yellowing, rashes, scars, tattoos, bruises, and/or needle marks;
- history of or current serious infectious disease, including tuberculosis;
- recent communicable illness symptoms, such as chronic cough, coughing up blood, lethargy, weakness, weight loss, loss of appetite, fever, and/or night sweats;
- history of or current sexually transmitted infections;
- history of or current illnesses or chronic health conditions including:
- allergies;
- asthma or other respiratory problems;
- dermatological conditions;
- seizure disorder;
- eye conditions; and
- other acute or chronic conditions as determined by the health service authority;
- history of or current gynecological problems;
- current or recent pregnancy;
- current use of medication(s) including name, dosage, frequency, time of last dose taken, and name of prescribing physician;
- dental problems;
- use of alcohol or illegal drugs, including type, amount, time of last use, and past treatment;
- drug withdrawal symptoms;
- special health requirements, such as dietary needs, physical disabilities, or prosthetics;
- evidence of physical trauma;
- recent injuries;
- weight and height; and
- any other health concerns reported by the resident.

The auditor verified that the 9 resident files inspected by the auditor included mental health and medical assessments that the intake officer could use to assist with completing the Behavioral Screen (risk screening).

115.341 (e):
Agency Policy 16.2 on page 2 states the requirements of this provision and states, "the information obtained through this process (the intake process to complete the Behavioral Screening and decide classification) shall only be shared on a need to know basis for

classification purposes in effort to ensure that sensitive information is not exploited to the juvenile's detriment by staff or other juveniles. Policy 16.2 also explains that any information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to medical and mental health practitioners and other staff, as necessary, for inform treatment plans and security and management decisions, including: housing, bed, work, education, and program assignments, or as otherwise by Federal, State, or local law. Additionally, Policy 12.5 on page 4 explains that apart from reporting to designated Supervisors or officials and designated State or local services agencies, staff shall be prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in departmental policy, to make treatment, investigation, and other security and management decisions.

The intake officer who conducts risk assessments stated to the auditor during her interview that only the intake officer conducting the intake, the Detention Supervisors, and the MHP have access to the resident's Behavioral Screening forms.

Additionally, the PREA Coordinator notified the auditor during his interview that all detention resident files are locked in the secure Central Control room, and the intake assessments (including the Behavioral Screen and mental/medical screenings) would only be available to the agency's MHP and Detention Supervisors. He also described that all such forms/assessments are not maintained on any computer files or an electronic system, and all documents used for the intake process are documented on paper.

The auditor was able to verify while onsite during the facility inspection that the resident files are kept securely in the Central Control room in a secure filing cabinet, and that only the Central Control room staff member can provide someone access into the control room. Additionally, the auditor inspected the intake area during the facility inspection, and the auditor was able to confirm that the intake area is a confidential and private area in which residents can safely and confidentially answer sensitive and private questions related to the intake assessments.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.342 Placement of residents

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.342

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 16.2 (Admissions Procedures) / Last updated: 6/16/2016
- Agency Policy 9.15 (Seclusions) / Last updated: 6/16/2016
- Facility Intake Behavioral Screen form
- Facility Protective Isolation Request/Authorization form
- Facility Protective Isolation Log
- 14 Disciplinary Seclusion Repots (randomly selected by the auditor)
- Texas Administrative Code 343.290 (Protective Isolation)

Interviews:

- Staff Responsible for Risk Screening
- Superintendent/PREA Coordinator (PC)
- Medical Staff (contracted registered nurse)
- Mental Health Practitioner (employed MHP)
- Staff who Supervise Residents in Isolation

Site Review Observations:

During the onsite audit, the Superintendent/PC explained to the auditor that the facility currently did not have a resident who identified as lesbian, gay, transgender, or intersex. Additionally, the auditor was advised by one Detention Supervisor and the Superintendent that the facility has never used Protective Isolation (PI) to protect a resident at risk of sexual victimization. During the onsite facility inspection conducted by the auditor, the auditor observed that the facility has the use of 6 PODS (two on each Dorm) that have 8 rooms per POD. It was explained to the auditor through many of the onsite interviews with administrators (Detention Supervisors and Superintendent) and randomly selected JSOs that if a resident is ever at risk of abuse, the resident's programming can easily be modified to include an one-on-one program (i.e., one staff with one resident) or a small group program (i.e., two or three residents on a POD) on one of the empty PODs. This was demonstrated by the agency when the auditor observed only two residents programming on Bpod with one staff member supervising; while Cpod had four residents and two staff members supervising. Additionally, due to the facility population being at 13 total residents and the facility being staffed for 40 (as indicated by the PAQ and Casework Manager), there were three empty PODs available for such a modified program. Furthermore, the auditor observed at least 5 staff working the 7-3 shift during the facility inspection; therefore, this further demonstrated how the agency could move residents around to different PODS, while remaining in ratio and providing the required direct line of supervision to each resident. Technically speaking, the agency could have placed each of the staff members on 5 of the PODS, with 2-3 residents per POD, if warranted for a

safety and security concern or threat.

Explanation of determination:

115.342 (a):
Agency Policy 16.2 on page 1-2 provides the requirements of this provision, and 16.2 states that all subsequent information obtained from the intake process (to include the Behavioral Screen, as pursuant to 115.341) shall be used to make housing, bed, program, education, an work assignments for residents with the goal of keeping all juveniles safe and free from sexual abuse.

The agency demonstrated the requirements of this PREA provision by providing the auditor with an example of how the classification system works- through use of the Behavioral Screening. The agency attached a copy of a completed Behavioral Screen for a resident admitted in 2019 into the Online Audit System's PAQ, and this completed screening form adequately demonstrates how the facility screens for risk of sexual victimization and sexual abusiveness through the use of their Behavioral Screening and uses this information to determine the safest housing assignment for the resident. The system is a type of checks and balances, with the intake officer completing the initial Behavioral Screen and the Detention Supervisor using the information from the screening to determine the best housing assignment.

The auditor reviewed 9 resident files that included 9 initial Behavioral Screens, and each Behavioral Screen established the same process of an intake officer completing the screening form and the Detention Supervisor documenting the recommending housing assignment (in which housing assignments include: bed, program, education, and work assignments). Additionally, the auditor identified that the agency's Intake Behavioral Screening form includes a note in between where the intake officer signs and dates and where the Detention Supervisor documents his/her recommendation for housing assignment, and this note states: "Information must be reviewed and taken into consideration in determining the initial recommendation housing assignment of this above resident." Out of the 9 completed Behavioral Screenings reviewed by the auditor, one indicated the screened resident as a potential victim of sexual abuse and the second indicated the resident as a potential aggressor of sexual abuse. The auditor verified with the PREA Coordinator and MHP that both residents were provided a follow-up with the MHP, and each resident's Behavioral Screening form indicated that the screening results were taken into account when deciding a housing location. Additionally, the MHP stated in her interview with the auditor that she follows up with every child who is referred to the facility, and this practice was also confirmed by the Casework Manager. No other screenings reviewed by the auditor reflected any other risk of being either a victim or perpetrator of sexual abuse while in detention.

An intake officer who conducts risk screenings for the facility was interviewed by the auditor, and she explained that information from the Behavioral Screening, such as the resident's age or information related to a victim of sexual abuse, would be used to ensure a resident is kept safe while in detention. This intake officer explained how if a resident makes an outcry of abuse, she would follow-up with this child to ask who the alleged perpetrator is in order to assure the child will not be placed in a housing unit with the alleged perpetrator.

Additionally, the Casework Manager explained to the Auditor that the JSO who conducts the admitted resident's intake, he/she reviews and considers the information on the intake Behavioral Screening form when deciding what POD and what room to place the juvenile in. This is also utilized to determine the programming groups the youth will be placed in. The Supervisor also reviews the risk screening form (Behavioral Screen) and the room placement to ensure that the placement was most appropriate for the safety and security of everyone in the facility. The Casework Manager continued to describe that the MHP reviews the Behavioral Screens to determine the priority that juveniles need to be assessed and treatment plans need to be developed. The MHP screens and assesses suicide juveniles first, then juveniles that fall in these high risk areas (as ascertained from the Behavioral Screen), then the general population until she has assessed everyone and they are all connected to the appropriate services for their needs. Additionally, the Casework Supervisor explained that the residents are usually grouped in programming assignments (education, groups, clean ups, etc.) according to the PODs they are assigned to; although, sometimes changes are made but this information is considered when determining which residents they are allowed to interact with.

115.342 (b):
Agency Policy 9.15 on page 4 outlines the agency's Protective Isolation (PI) procedures, and it should be noted that the agency utilizes Protective Isolation when a juvenile is physically threatened by another juvenile or a group of juveniles (i.e., risk of sexual victimization) and less restrictive measures are inadequate to keep the juvenile safe. Per Policy 9.15, "during the isolation period, the department shall not deny the juvenile daily large-muscle exercise and any legally required educational programming or special education services. Juveniles in isolation shall receive daily visits from the Mental Health Practitioner (MHP) or Medical Staff and shall have access to other programs and work opportunities to the extent possible." Additionally, Policy 9.15 describes the review process for continuing a PI past 24 hours, which includes the following procedures: "After the initial 24 hours and every 72 hours thereafter, the Detention Superintendent or designee shall conduct a documented review of the circumstances surrounding the level of threat faced by the juvenile and make a determination whether the PI should continue or whether less protective restrictions can take place. However, if PI is to be continued, the Superintendent or designee shall ensure that review documentation includes an alternative service delivery plan to ensure that the resident is afforded the required program services while in PI."

Additionally, the auditor reviewed the agency's PI Request/Authorization form, which provides an example of how the agency documents placing a resident on PI. The form includes a space for the resident's name, date/time, room number, who the PI request is against (the threat), narrative/reason for isolation, staff signature, who authorizes, observations made, etc. The agency also provided the auditor with their PI log, which documents any resident placed on PI, the date of isolation request and date of isolation, reason, and date of removal from isolation. The agency reported in the PAQ that they had zero resident's placed on any type of isolation who were deemed at risk of sexual victimization in the past 12 months, and the auditor was able to verify this by reviewing the PI log and interviewing the Superintendent, a staff who supervises residents in isolation, the MHP, and a contracting nurse (as explained below). Additionally, the Auditor reviewed 14 randomly selected disciplinary seclusion reports from the past 12 months in order to verify that the facility has not placed a resident in a seclusion for an incident of alleged sexual abuse or sexual harassment, and each report reviewed did not

indicate a resident being involved in such an incident.

The Superintendent advised the auditor during his interview that residents are only isolated from others 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. He explained that he has never had to place a child on a Protective Isolation for being at risk of sexual victimization, and that if a child deemed to be at such a risk, the agency is able to modify the PODs to house a resident in a small group (i.e., 2 to 3 residents) to ensure safety. The Superintendent also clarified how each PI would be reviewed by administration before being initiated, that the Chief would make the final approval, and that the PI would then be reviewed daily (every 24 hours) until the child is removed off the PI.

A staff member who supervises residents in isolation was interviewed by the auditor, and he described the facility's process of placing a child on a PI. This officer explained that a resident on a PI would have access to programs, privileges, education/special education, and work opportunities. He also stated that a resident who is placed on a PI would only be placed in isolation until an alternative means of separation from the likely abuser or threat can be arranged, and that in most cases, a modified group can be quickly arranged to eliminate the need of isolating due to a safety concern or threat. The officer stated that he has never been involved in a situation involving a resident being placed on PI (over 20 years of working in the facility), and explained that if such an incident occurred, the resident would only be kept in isolation until alternative means of keeping the resident safe could be implemented. He provided information that the PI would be reviewed by administration every 24 hours, and that medical and mental health staff would never be turned away for a resident in a PI.

The agency's MHP was interviewed by the auditor and confirmed that mental and medical health staff are able to visit with residents in isolation every day. It was explained that a resident has never been placed in a Protective Isolation for being at risk of sexual abuse, but that the MHP does routinely check on residents in their room (i.e., serving a disciplinary seclusion) just to check in and ensure the resident is ok.

The agency's contracted registered nurse explained to the auditor during her interview that mental and medical staff routinely conduct visits with residents, regardless if a resident is in a secure room or not. Additionally, it was explained that a resident has never been placed in a Protective Isolation for being at risk of sexual abuse (as far as she knew) and that all residents are able to visit with a medical or mental health practitioner if needed and as required.

The Casework Manager explained that if a situation occurred that the Facility places a resident on PI for being at risk of sexual victimization, the Agency would work out a schedule for the MHP and/or one of the contracting nurses to visit the resident on PI every day, even if it is not their regular scheduled day. The MHP is able to flex her time elsewhere as needed or earn comp time to be utilized at a more convenient time, or the nurse would be compensated for the time they entered the facility to see the resident. The Casework Manager also described how the Agency can contact a Qualified Mental Health Provider (QMHP) from Spindletop Services to counsel with the resident if needed.

Additionally, it should be noted that Texas Administrative Code 343.290 (Protective Isolation) requires the agency to adhere to the following guidelines when placing a child on PI:

- Protective isolation may be used as a last resort only when:
- a resident is physically threatened by a resident or a group of residents;
- less restrictive measures are inadequate to keep the resident safe; and
- the decision is approved in writing by the facility administrator.

Protective isolation may be used only until alternative means for keeping the resident safe can be arranged.

115.342 (c):
Agency Policy 16.2 on page 2 outlines the requirements of this PREA provision, and the Policy states, “Lesbian, gay bisexual, transgender, or intersex juveniles shall not be placed in particular housing, bed, o other assignments solely on the basis of such identification or status. Nor shall the Department consider lesbian, gay, bisexual, transgender, or intersex (LGBTI) identification or status as an indicator of likelihood of being sexually abusive.” During the auditor’s observations and interactions with the resident population from the onsite visit; the auditor did not witness a resident who identified as LGBTI in a separate housing unit, did not observe a special housing unit for residents who identify as LGBTI, and at no time was the auditor made aware of a resident in the detention center who identified as LGBTI. Additionally, the auditor reviewed 9 resident detention files, and analyzed each resident’s Behavioral Screen to check for any residents who identified as LGBTI. Upon review, all 9 resident Behavioral Screening’s indicated that all 9 residents identified as straight or heterosexual when screened in intake or during their applicable periodic reassessment (pursuant to 115.341).

The auditor interviewed the PREA Coordinator, who is also the Detention Superintendent, and he advised that the facility does not have a special housing unit for LGTI residents and that the agency does not single out residents due to how they personally identify themselves.

115.342 (d), (e), and (f):
Agency Policy 16.2 on page 2 explains that the facility shall take into consideration on a case-by-case basis whether to assign a transgender or intersex juvenile to a dorm for a male or female juvenile and in making other housing and programming assignments. This Policy also states that each such case will be reviewed by the agency to ensure the juveniles health and safety, and whether the placement would present management or security problems.

Additionally, Policy 16.2 on page 4 states that placement and programming assignments for each transgender or intersex juveniles shall be reassessed at least twice each year to review any threats to safety experienced by the juvenile, and that a transgender or intersex juveniles own views with respect to his/her own safety shall be given serious consideration. Due to the Facility reporting to the Auditor that they have never had a transgender or intersex resident in the facility and the average length of stay in the past 12 months as being 20 days, this procedure has never been conducted. Although, the Casework Manager advised that if a transgender or intersex resident is referred to the Facility, the applicable resident/s would be added to the list to be screened and placement reassessed every thirty (30) days, as the facility does for all other residents during the periodic reassessments.

The intake officer who conducts risk screenings informed the auditor during her interview that

she has never processed a referral in intake who identified as transgender or intersex, and that a transgender or intersex residents' views of their safety would be given very serious consideration in placement and programming assignments.

As noted previously in this report, the agency's Superintendent advised the auditor that the facility has never had a resident admitted who identified as a transgender or intersex resident, and that Policy 16.2 would be adhered to if such a child is ever referred to the facility.

During the onsite audit, the auditor did not observe and was not made aware of a resident who identified as transgender or intersex. Furthermore, the auditor reviewed 9 of the available 13 currently detained resident Behavioral Screens while onsite, and each screening did not indicate that the applicable child identified as transgender or intersex during the initial screening or during the applicable reassessments.

115.342 (g):
Agency Policy 14.3 on page 2 describes that transgender and intersex residents shall be given the opportunity to shower separately from other residents, and the agency noted in the PAQ that such residents are given the opportunity to shower separately from other residents.

Additionally, the auditor was able to verify onsite that every resident showers alone, regardless of the situation. During the onsite audit, the auditor observed that Apod, Cpod, Dpod, and Fpod are the only PODs with shower areas, and Bpod and Epod are PODs that can house residents but do not have showers. The shower areas on each applicable POD are individual showers, and the auditor verified that residents are able to shower without being viewed on camera by reviewing male shower times on the agency's surveillance camera system from the previous day. The auditor observed each male resident go into the shower dressed and by themselves, and then exit the shower fully dressed and by themselves. At no time, was more than one resident in the shower at a time. The auditor also was provided access to the agency's intake processing area, which are two rooms with each room having an office area and one individual shower area for incoming juveniles to shower and change. All areas, except the shower areas, of both intake processing rooms are continuously monitored by surveillance cameras, as verified by the auditor during the facility inspection and through reviewing camera surveillance video while inspecting the facilities central control room.

Additionally, the intake officer who conducts risk screenings also verified during her interview that all residents shower separately, one at a time.

The Detention Superintendent verified the practice as well, stating to the auditor that all residents shower one at a time.

115.342 (h):
The agency noted in the PAQ that they have had zero residents who were deemed at risk of sexual victimization and who were held in isolation in the past 12 months. Furthermore, the auditor reviewed the agency's Protective Isolation Log that did not indicate any residents who was placed on PI in the past 12 months for any reason. The auditor also reviewed 14 randomly selected disciplinary seclusion reports from the past 12 months to ensure the agency never placed a child in any type of isolation that involved a resident who was at risk or was sexually abused, assaulted, or harassed; and each of the 14 disciplinary reports analyzed

did not involve a sexual abuse or sexual harassment type incident.

Additionally, the Detention Superintendent and the Detention Supervisor advised the auditor during an informal conversation that they have never had to place a child on PI for being at risk of being sexually victimized while they have worked for the agency.

115.342 (i):
Policy 9.15 describes the review process for continuing a PI past 24 hours, which includes the following procedures: “After the initial 24 hours and every 72 hours thereafter, the Detention Superintendent or designee shall conduct a documented review of the circumstances surrounding the level of threat faced by the juvenile and make a determination whether the PI should continue or whether less protective restrictions can take place. However, if PI is to be continued, the Superintendent or designee shall ensure that review documentation includes an alternative service delivery plan to ensure that the resident is afforded the required program services while in PI.” The facility exceeds the provisions of this standard by requiring a PI review every 72 hours; the provision requires this to be done every 30 days.

Additionally, the auditor reviewed the agency’s PI Request/Authorization form, which provides an example of how the agency documents placing a resident on PI. The form includes a space for the resident’s name, date/time, room number, who the PI request is against (the threat), narrative/reason for isolation, staff signature, who authorizes, observations made on each applicable day, etc. The agency also provided the auditor with their PI log, which documents any resident placed on PI, the date of isolation request and date of isolation, reason, and date of removal from isolation. The agency reported in the PAQ that they had zero resident’s placed on any type of isolation who were deemed at risk of sexual victimization in the past 12 months, and the auditor was able to verify this by reviewing the PI log and interviewing the Superintendent, and a staff member who supervises residents in isolation

The Superintendent advised the auditor during his interview that residents are only isolated from others 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. He explained that he has never had to place a child on a Protective Isolation for being at risk of sexual victimization, and that if a child deemed to be at such a risk, the agency is able to modify the PODs to house a resident in a small group (i.e., 2 to 3 residents) to ensure safety. The Superintendent also clarified how each PI would be reviewed by administration before being initiated, that the Chief would make the final approval, and that the PI would then be reviewed daily (every 24 hours) until the child is removed off the PI.

A staff member who supervises residents in isolation was interviewed by the auditor, and he described the facility’s process of placing a child on a PI. This officer explained that a resident on a PI would have access to programs, privileges, education/special education, and work opportunities. He also stated that a resident who is placed on a PI would only be placed in isolation until an alternative means of separation from the likely abuser or threat can be arranged, and that in most cases, a modified group can be quickly arranged to eliminate the need of isolating due to a safety concern or threat. The officer stated that he has never been involved in a situation involving a resident being placed on PI, and explained that if such an incident occurred, the resident would only be kept in isolation until alternative means of keeping the resident safe could be implemented. He provided information that the PI would be

reviewed by administration every 24 hours, and that medical and mental health staff would never be turned away for a resident in a PI.

Additionally, the Casework Supervisor advised the auditor that if a transgender or intersex resident were to be referred to the facility, the facility would listen to the resident's concerns about their own views of his/her safety. She also described how the facility would accommodate the resident's concerns to the best of their ability, while still following standards and maintaining the safety and security of the facility, and that each accommodation would be determined by management on a case-by-case basis.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.351 Resident reporting

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.351

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 12.5 (Sexual Abuse & Mistreatment) / Last updated: 09/02/2016
- Agency Policy 12.4 (Juvenile Grievance Procedures) / Last updated: 12/16/16
- Agency Policy 15.12 (Notification and Reporting Illness, and Investigating Abuse, Exploitation or Death) / Last updated: 06/16/2016
- Detention Handbook (both Spanish and English)

Interviews:

- Random Sample of Staff
- Random Sample of Residents
- PREA Coordinator (PC)

Site Review Observations:

During the onsite audit, the auditor observed the grievance box in the dining room, the external reporting phone in the library (TJJD Hotline), and posters posted throughout the facility explaining how a resident can report abuse and harassment. The auditor conducted a test call during the onsite facility inspection through the TJJD Hotline, and the call was completed successfully.

Explanation of determination:

115.351 (a) & (b):
Agency Policy 12.5 on page 3 outlines the multiple internal ways for residents to report privately to agency officials about sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violations of responsibilities that may have contributed to such incidents. The methods described in this Policy are:

- The TJJD 24-hour hotline (external reporting method- phone is located in the library and allows juveniles to remain anonymous);
- Any departmental staff member or supervisory staff;
- Any law enforcement agency; or
- Written report through grievance process (as described in Policy 12.4).

The PC explained to the auditor that all residents in the MRJJC can report through using the TJJD Hotline phone (external reporting method), to any staff member, and through the resident grievance process.

Policy 12.4 outlines the MRJJC's procedures for handling resident grievances, including grievances related to this PREA standard. This Policy explains that juveniles have the ability to submit a grievance with full access to the grievance process, including forms and methods of submission, and that all grievance forms shall be submitted to the Detention Superintendent (PREA Coordinator) or designee by placing the grievance form in the Grievance/Sick Call box in the dining hall or submit to a Supervisor. Additionally, 12.4 states that all grievances shall be confidential, with access being limited to those involved with providing responses and administrative review, and that the Detention Superintendent and Detention Casework Supervisors will serve as the Grievance Officers for the MRJJC.

The auditor also reviewed the facility's Resident Handbook that outlines the same reporting methods that are listed in Policies 12.4 and 12.5, as explained above. More specifically, page 17 of the Resident Handbook states that residents have the right to confidentially report sexual assault, abuse, or harassment; and that residents can tell any JSO, JPO, Counselor, volunteer, intern, Lead Supervision Officer (LSO), or any member of the Supervisory Staff. The Handbook also states that residents can use the hotline to contact TJJD directly or write an allegation on a grievance form and submit in the grievance box.

Additionally, twelve (12) of the randomly selected staff members interviewed by the auditor were able to clearly explain multiple ways residents can privately report abuse and harassment, retaliation for reporting, and staff neglect. The auditor determined through the random staff interviews that all staff were aware of how residents can privately report abuse, harassment, retaliation, or staff neglect (pursuant to this PREA standard) to a staff member, teacher, volunteer, medical or mental health staff, and their parents or attorney; utilize the TJJD Hotline to an outside agency; and how residents can file a grievance.

The eleven (11) resident's interviewed by the auditor all were able to clearly explain how they are able to report any sexual abuse or sexual harassment, and the residents were aware of the TJJD Hotline phone, grievance procedures, and how they can tell a staff member or volunteer.

It was reported to the auditor by the PC that the MRJJC does not detain residents solely for civil immigration purposes and this prohibition is also documented in Policy 12.5 on page 2.

115.351 (c):
Policy 12.5 on page 2 outlines the requirements of this PREA provision and states, "any department employee, volunteer, or contractor who has cause to believe that a juvenile in any program or facility under the department's jurisdiction has been or may be subjected to an act or threat of sexual abuse and sexual harassment or receives a report of sexual abuse or possible sexual abuse and sexual harassment, whether verbally or in writing, anonymously, and from third parties must immediately notify the proper authorities in accordance with departmental policy, TJJD Standards, and state law. Additionally, 12.5 states that all verbal reports must be promptly documented.

The auditor interviewed 12 randomly selected JSOs who explained that when a resident alleges sexual abuse or sexual harassment, the resident can do so verbally, in writing, anonymously, and through third parties. Staff were able to clearly articulate how residents can

report verbally and staff's responsibilities for accepting verbal reports, how residents can report in writing with a grievance, and anonymously through a grievance without a name or the Hotline without giving a name, and through third parties (i.e., the TJJD Hotline and parents/guardians/attorney). Staff advised that they would not wait to document a verbal report (documentation would be made immediately after the initial report), and that such a report would be documented and sent up the chain of command immediately.

Furthermore, the auditor also interviewed 11 randomly selected residents who were able to explain that all residents are able to make reports of sexual abuse or sexual harassment either in person or in writing and how a person can make such a report on their behalf (third party). Some examples provided by the residents to the auditor include: telling a staff member or counselor they trust, documenting a report on a grievance or a letter (and how to submit the grievance or letter in the grievance box), calling the TJJD Hotline, and telling their parent, JPO, Judge, or attorney.

115.351 (d):
Policy 12.4 on page 2 explains that juvenile's will have full access to grievance forms to make written reports pursuant to this PREA provision, and in the Resident's Handbook on page 14 it is documented that a grievance form and pencil will be provided to a resident who wishes to submit a grievance. Additionally, the PC advised the auditor that grievance forms and pencils are made available to juveniles to write grievances and residents can place the grievances in the grievance box or turn into staff.

115.351 (e):
Agency Policy 12.5 on page 3 outlines the multiple internal ways for staff or a person advocating on behalf of a juvenile to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violations of responsibilities that may have contributed to such incidents. The methods described in this Policy are:

- The TJJD 24-hour hotline (external reporting method- phone is located in the library and allows juveniles to remain anonymous);
- Any departmental staff member or supervisory staff;
- Any law enforcement agency; or
- Written report through grievance process (as described in Policy 12.4).

Additionally, the PC advised the auditor that all staff, contractors, and volunteers are trained on PREA and how to privately report abuse, neglect, and exploitation (to include sexual abuse and sexual harassment). The PC also advised that the reporting phone numbers (law enforcement- JCSD and TJJD) and applicable reporting policies are provided to each person during training. Also, it should be noted that the PC explained, and the auditor verified onsite, that the MRJJC has posted PREA reporting related posters throughout the facility and outside the facility in the visitation public waiting area. The auditor verified onsite that the posters (titled: "End the Silence") include the telephone number for privately reporting any type of abuse or harassment to the Texas Juvenile Justice Department (TJJD).

Lastly, the auditor interviewed 12 randomly selected JSOs who explained how staff can privately report to a supervisor or administrator, contact the TJJD Hotline, or contact the

Sheriff's Department (JCSD). It should be noted that each staff member interviewed described how the agency has an open door type policy for talking to their immediate supervisor or administrators about concerns or issues and for reporting any type of incident, including sexual abuse or sexual harassment.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.352 Exhaustion of administrative remedies

Auditor Overall Determination: Exceeds Standard

Auditor Discussion

115.352

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 12.4 (Juvenile Grievance Procedures) / Last updated: 12/16/2016
- Agency Policy 12.5 (Sexual Abuse & Mistreatment) / Last updated: 09/02/2016
- Resident Handbook

Explanation of determination:

115.352 (a):
Agency Policies 12.4, 12.5, and the Resident Handbook includes administrative procedures for addressing resident grievances regarding sexual abuse administratively. Policy 12.4 outlines the agency's procedures for a resident grievance in general, with Policy 12.5 including detailed procedures in regards to this PREA standard.

115.352 (b):
Policy 12.5 on page 3 explicitly states all the requirements of this provision (1-4), and it should be noted that the agency documented in the PAQ for this provision that they do NOT require a resident to use an informal grievance process, or otherwise, to attempt to resolve with staff an alleged incident of sexual abuse. Additionally, the auditor verified that the agency includes their grievance procedures in the Resident Handbook, and it was confirmed that each resident receives a Handbook and grievance information (orientation) during the intake process (as outlined in section §115.333 of this report). It is also documented in Policy 12.4 on page one (1) that upon admission, juveniles shall be informed of their right to file grievances against any behavior or disciplinary action of staff or other juveniles, and that all grievances shall be handled confidentially, expeditiously and without threat to or reprisals against the grievant.

115.352 (c):
Policy 12.5 on page 3 states that the department shall ensure that a juvenile who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the compliant, and such grievance is not referred to a staff member who is the subject of the complaint. Additionally, it should be noted that Policy 12.4 on page 2 states that grievance forms shall be submitted to the Superintendent or designee by placing the grievance form in the Grievance/Sick Call box in the dining hall or submit to a Supervisor, and that all grievances shall be confidential, with access being limited to those involved with providing responses and administrative review. The auditor verified the location of the Grievance Box in the dining room during the facility inspection, and the PC explained to the auditor that all residents are provided access to the dining room three times a day for breakfast, lunch, and dinner. Additionally, 12.4 explains that upon receipt, the grievance will be assigned a tracking number and assigned to the appropriate Grievance Officer for resolution (with the Detention Superintendent and two Detention Casework Supervisors serving as

Grievance Officers). This Policy explains that the Chief Probation Officer must be notified immediately of all complaints against staff members of a serious nature and the Superintendent (PC) or designee must be notified of all other complaints. With the agency having this additional step of notifying the Chief of any serious complaints against staff (including sexual abuse or sexual harassment) and the procedure of notifying the PREA Coordinator/Superintendent, the auditor was able to determine that if an allegation of abuse is against a Grievance Officer (i.e., against the Superintendent or one of the two Casework Supervisors), the agency has protocols in place that an additional administrator would be notified (i.e., the Chief, who is not a grievance officer).

Lastly, the auditor was able to verify that the agency's grievance procedures are documented in the Resident Handbook, and each resident is provided a Handbook and orientation related to how to submit a grievance during the intake process (as noted in section 115.333 of this report).

115.352 (d):
The auditor was advised by the Casework Manager that any grievance alleging a resident has been sexually abuse or sexually harassed in the MRJJC would immediately initiate an administrative investigation by the agency and law enforcement would be immediately contacted (with all first responder protocols adhered to as outlined in standard explanation §115.322), and that the investigation would take precedent over the grievance in order to ensure the resident's safety. Additionally, the Grievance Officer would then provide a resolution (final agency decision) to the grievance at the time that agency staff were made aware of the allegation (same day); with documenting on the grievance that an administrative investigation was initiated by the agency and advising the resident of the resolution and pending investigation. MRJJC Policy 12.4 on page 2 states that for grievances regarding sexual abuse, sexual harassment, and/or substantial risk of imminent sexual abuse to refer to procedures in policies 12.5 (Sexual Abuse & Mistreatment) and 15.12 (Investigative Procedures). Policies 12.5 and 15.12 are explained in more detail by the auditor in the standard explanation for §115.322; which includes the agency's requirement from Policy 12.5 on page 7 describing the agency's requirements to ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. The auditor determined that the agency substantially exceeds the requirements of this PREA provision by ensuring all grievances, alleging not only sexual abuse but also sexual harassment, are immediately processed as a sexual abuse allegation- with the agency issuing a final decision of the grievance as initiating an investigation and reporting to the proper law enforcement authorities. Additionally, the auditor determined that since Policy 12.4 indicates that the agency's Grievance Officer collects grievances every day and the agency provides a final resolution to a grievance alleging sexual abuse or sexual harassment on the same day as when staff are made aware of the allegation, the agency, again, substantially exceeds this PREA provision's requirement of issuing a final decision within 90 days of the initial filing of the grievance by 89 days. Furthermore, no extension of time to respond to the grievance would be applicable due to the final resolution being the initiation of the investigation on the same date of the receipt of the grievance alleging sexual abuse or sexual harassment.

It should be noted that the agency does have procedures in place for grievance appeals up to two levels; although, such an appeal for a grievance alleging sexual abuse or sexual harassment would not be applicable in this situation due to the resolution of the grievance

being the initiation of the administration investigation and reporting the allegation to the proper law enforcement authorities, as mentioned above. For purposes of transparency as to the agency's appeal process for a grievance, as documented in Policy 12.4, the procedures include the following levels of appeal (which provide for a total of 15 days through two levels of appeals until the final level of appeal is exhausted):

- After a grievance is submitted, the agency has two working days to respond to the grievance.
- After the resident receives the response, he/she can elect to accept the resolution or request for an appeal.
- Upon the agency receiving the first level of appeal request, the agency shall address the appealed grievance within two working days of the appeal request; with the level one appeal findings documented on the grievance and a copy given to the juveniles as soon as possible but no later than 10 calendar days from the date the grievance appeal is received.
- If the juvenile desires to appeal the first level of appeal, he/she may appeal to the Chief Probation Officer, as the final appeal authority. The Chief Probation Officer will address the appeal within three working days of receipt.

The agency documented in the corresponding PAQ section that they have had zero grievances in the past 12 months that were filed alleging sexual abuse; therefore, the agency also reported zero grievance decision extensions and zero final grievance decisions surpassing the 90 day deadline.

Additionally, the PREA Coordinator provided the auditor with the facility's Grievance Log for 2019, which included a total of nine (9) grievances submitted. The PC advised that the facility has not received a grievance in the past 12 months alleging sexual abuse or sexual harassment, and this was verified by the auditor upon review of the grievance log attached in the PAQ and the 2019 grievance log provided onsite, which both items did not reflect any such grievances being submitted. The auditor randomly selected three (3) grievances to review for sexual abuse or sexual harassment allegations (33%), and the PC provided the auditor with each original grievance form. Upon review, all the grievances reviewed (100%) were NOT related to sexual abuse or sexual harassment.

115.352 (e):
Policy 12.5 on page 3 outlines the agency's responsibilities of this PREA provision of permitting third parties to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse and to file on their behalf (i.e., filing a grievance on a resident's behalf). Agency policy 12.5 also describes how if a third party, other than a parent or legal guardian, files such a request on behalf of a juvenile, the department may require as a condition for processing the request that the allege victim agree to have the request filed on his/her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process. Furthermore, if the juvenile declines to have the request processed on his/her behalf, the department shall document the juvenile's decision; and 12.5 also states that a parent or legal guardian of a juvenile shall be allowed to file a report regarding allegations of sexual abuse, including appeals, on behalf of such juvenile. Such a report shall not be conditioned upon the juvenile agreeing to have the request filed on his/her behalf.

The agency reported in the applicable section of the PAQ that they have had zero grievances

alleging sexual abuse filed by residents in the past 12 months; and therefore there were zero residents who declined third-party assistance.

Additionally, the PREA Coordinator provided the auditor with the facility's Grievance Log for 2019, which included a total of nine (9) grievances submitted. The PC advised that the facility has not received a grievance in the past 12 months alleging sexual abuse or sexual harassment, and this was verified by the auditor upon review of the grievance log attached in the PAQ and the 2019 grievance log provided onsite, which both items did not reflect any such grievances being submitted. The auditor randomly selected three (3) grievances to review for sexual abuse or sexual harassment allegations (33%), and the PC provided the auditor with each original grievance form. Upon review, all the grievances reviewed (100%) were NOT related to sexual abuse or sexual harassment.

115.352 (f):
Agency Policy 12.4 on page two (2) states that for grievance regarding sexual abuse, sexual harassment, and/or substantial risk of imminent sexual abuse refer to procedures in Policy 12.5 (Sexual Abuse & Mistreatment) and 15.12 (Investigative Procedures). Policy 12.5 on page 3 explains that in the event an emergency grievance is filed that alleges a resident is subject to imminent risk of sexual abuse, the grievance will immediately be forwarded to the Superintendent (PC) or designee, and that immediate corrective action will be taken to protect the juvenile. 12.5 also states that the Superintendent or designee will issue an initial response to the grievance within 48 hours and shall issue a final department decision within 5 calendar days, and that the initial and final response shall document the department's decision regarding whether the juvenile is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance. Additionally, Policy 12.5 on page four (4) states that any grievance in regards to sexual abuse or sexual harassment will initiate an internal investigation.

The agency documented in the corresponding PAQ section that they have had zero emergency grievances in the past 12 months that were filed alleging a resident was subject to imminent risk of sexual abuse; therefore, there were also zero grievances that required any type of applicable response.

Additionally, the PREA Coordinator provided the auditor with the facility's Grievance Log for 2019, which included a total of nine (9) grievances submitted. The PC advised that the facility has not received a grievance in the past 12 months alleging sexual abuse or sexual harassment, and this was verified by the auditor upon review of the grievance log attached in the PAQ and the 2019 grievance log provided onsite, which both items did not reflect any such grievances being submitted. The auditor randomly selected three (3) grievances to review for sexual abuse or sexual harassment allegations (33%), and the PC provided the auditor with each original grievance form. Upon review, all the grievances reviewed (100%) were NOT related to sexual abuse or sexual harassment.

115.352 (g):
Policy 12.5 on page 3 states that the department may discipline a juvenile for filing a grievance related to alleged sexual abuse only where the department demonstrates that the juvenile filed the grievance in bad faith. Additionally, the agency reported in the PAQ that they have had

zero grievances alleging sexual abuse that resulted in disciplinary action by the agency against the resident for having filed the grievance in bad faith.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency substantially exceeds all elements of this standard. No corrective action is required.

115.353 Resident access to outside confidential support services and legal representation

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.353

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 12.5 (Sexual Abuse & Mistreatment) / Last updated: 09/02/2016
- Agency Policy 12.1 (Legal Rights of Juveniles) / Last updated: 09/01/2013
- Agency Policy 18.2 (Access to Telephone) / Last updated: 12/17/2015
- Agency Policy 18.3 (Juvenile Visitation) / Last updated: 09/01/2013
- Cooperative Working Agreement between Rape and Suicide Crisis of Southeast Texas and Jefferson County Juvenile Probation Department (JCJPD) for 2019 – 2021 (as well as the previous agreement active from 2016 – 2018)
- Garth House (Mickey Mahaffy Children's Advocacy Program, Inc.) Best Practice Guidelines: Jefferson County Working Protocols (Effective from 2016 to present day)
- Information for Parents, Guardians, and Custodians Regarding PREA form (on agency website)

Interviews:

- Randomly Selected Residents
- Detention Superintendent (PREA Coordinator/PC)

Site Review Observations:

During the onsite audit, the auditor observed Resident Handbooks in the resident rooms he inspected, and he also observed the visitation area and counselor rooms (where attorney visits can take place in a confidential manner). The visitation area included non-contact rooms for parent/guardian visits. The counselor rooms observed by the auditor were private and only utilized camera surveillance in order to ensure the safety of the residents and person visiting with the resident.

Explanation of determination:

115.353 (a):
Policy 12.5 on page 9 outlines the agency's requirements of providing to a victim of sexual abuse a victim advocate from the Rape and Suicide Crisis Center of South East Texas. The facility provides residents with access to such services by including the name, address, and telephone number in the Resident Handbook on page 23. The Resident Handbook also provides contact information for the following Jefferson County resources:
- Family Services of Southeast Texas
- Spindletop MHMR Services

- Crisis Hotline
- Beaumont- Daybreak Interagency Youth Services
- Buckner Children and Family Services
- Youth Crisis/Runaway Hotline

Additionally, Policy 12.5 states that the Detention Superintendent (PC) or designee will arrange communication for juveniles when a victim advocate is requested or needed.

The JCJPD provided the auditor with their current Cooperative Working Agreement with the Rape and Suicide Crisis of SE TX, Inc (RSCST). This agreement outlines a collaborate effort by the JCJPD and the RSCST to provide a continuum of services as needed for sexual assaulted or sexually abused youth housed at the MRJJC. The Agreement requires the JCJPD to:
- Contact and report to the RSCST that a juvenile has been sexually assaulted or sexually abused while at the MRJJC or occurred prior to arriving at MRJJC but reported while at the facility.
- Contact and report to the RSCST upon the request of a juvenile victim of sexual assault or sexual abuse while at the MRJJC or occurred prior to arriving at the MRJJC but reported while at the facility.
- Allow a juvenile victim at MRJJC to contact a representative of the RSCST for assistance.
- Allow a representative of the RSCST access to the juvenile victim.

The Agreement also outlines the responsibilities that the RSCST agrees to, which includes:

- Demonstrate an average 60 minute response time from time call is received to time advocate arrives in the emergency department.
- Follow established protocols with the associated hospital that is conducting the SANE/SAFE exam for advocates in the examining room.
- Be available for survivors of all ages, their family members and friends.
- Maintain communication and contact with Sexual Abuse Review Team (SART) and other involved agencies, including regular participation at the Southeast Sexual Assault Task Force meeting.

The auditor also interviewed a Crisis Specialist from the RSCST that explained that an advocate from her agency would immediately be provided to a victim of sexual abuse that is referred from the MRJJC. She described that an advocate stays with the victim throughout the initial meeting and through the aftercare process. The RSCST was described to be a non-profit 504 organization, and the victim and the victim's family is never charged for any services provided by the RSCST. The Crisis Specialist explained that her office is open and available during normal business hours; although, if the services of the RSCST are required after hours, there is a hotline number that is answered 24/7.

The JCJPD provided the auditor with a Working Protocols agreement between the Agency and Garth House (Mickey Mehaffy Children's Advocacy Program, Inc) that includes victim advocacy services for a resident in the MRJJC who has experienced sexual abuse. The Garth House is described in the document as responsible for facilitating the coordination of a multidisciplinary team (MDT) that responds to allegations of child abuse in Southeast Texas and provides victim advocacy, case tracking, and mental health services. The Working

Protocols includes the following advocacy services:

- Orients the child and family to the interview process including a brief tour of the interview room and explanation of the camera and recording system.
- Meets with the caregiver during the forensic interview to provide support and information regarding the MDT and criminal justice process.
- Provides crisis intervention including assessing the need for other services.
- Provides written information including the booklet, “A Handbook for Parents” with names and contact information of the investigators involved.
- Provides the information for caregivers regarding the rights of crime victims, refers the family to the Crime Victims Assistance Office and provides Crime Victims Compensation applications.
- Makes referrals as needed to other community resources and provides information about counseling.
- Follows the case through the legal system updating the status of the case in Case Tracking including final disposition.
- Maintains contact with the family during the investigation and prosecutorial processes.

The Executive Director of the Garth House was interviewed by the auditor, and she confirmed that the Working Protocols Agreement is an active and working agreement between the JCJPD and the Garth House.

The JCJPD also explained to the auditor that the agency employs a fulltime qualified staff member that is available onsite at any time, in the case that a rape crisis center or Garth House advocacy person is not available for a victim of sexual abuse. The qualified staff member is the agency’s Mental Health Provider (MHP), and the agency provided the auditor with the MHP’s licensing documentation from the Texas Department of State Health Services. The documentation proves that the agency’s MHP holds a current State license as a Sex Offender Treatment Provider (LSOTP) and as a Professional Counselor (LPC).

The auditor interviewed a targeted resident who reported to an intake officer during the intake process that she had been sexually assaulted while in the community prior to her last detention (reported on the agency’s risk screening- Behavioral Screening, as verified by the auditor). The resident informed the auditor that when she first made the outcry during her last detention stay a few months ago, the report was for an incident that occurred in 2018 that remains to be an open investigation with the Beaumont Police Department. She also explained that during her last detention stay, she was introduced to the Garth House organization, and they arranged for a SANE exam and advocate. The SANE exam was performed at Baptist Hospital and the Garth House assigned her an advocate that was with her throughout the process and met with her afterwards at the Detention Center. The resident stated that this all occurred during her last detention stay, and during this most recent detention, she explained that the MRJJC provided her a follow-up with the agency’s MHP due to reporting the prior abuse during this most recent intake. The resident explained that this face-to-face meeting with the MHP occurred the day after being admitted.

115.353 (b):
Policy 12.5 states that prior to giving a resident access to an advocate, the Superintendent or designee will inform the juvenile 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.

Additionally, it should be noted that the Garth House Working Protocols document the following information as related to confidentiality:
- MDT members are routinely reminded of the confidential nature of the information shared in Case Review and asked to sign a form acknowledging their commitment to protecting the integrity of the MDT process by keeping shared information confidential.
- Mental Health records are kept in compliance with Title 22, Texas Administrative Code, Chapter 681 (LPC Board Rules) and Texas Health & Safety Code, Chapter 611 regarding maintaining confidential mental health information.
- Before a forensic interview is conducted, the forensic interview process is explained more fully by assigned Family Advocate and the Family Advocate obtains a written waiver of confidentiality from the child's parent or caregiver.

115.353 (c):
As documented in provision (a) of this PREA standard explanation of determination, the MRJJC has written agreements with the following two agencies:

- Cooperative Working Agreement between Rape and Suicide Crisis of Southeast Texas and Jefferson County Juvenile Probation Department (JCJPD) for 2019 – 2021 (as well as the previous agreement active from 2016 – 2018); and

- Garth House (Mickey Mahaffy Children's Advocacy Program, Inc.) Best Practice Guidelines: Jefferson County Working Protocols (Effective from 2016 to present day)

Upon review by the auditor, both agreements are current (per the documented dates) and active (per the included signatures).

115.353 (d):
Agency Policy 12.1 on page one states, "juveniles will be assured that seeking judicial relief will not be met with reprisal or penalty and will have uncensored, confidential contact by telephone, in writing, or in person with their legal representative (attorney)." Additionally, Policy 12.1 explains that a juvenile's written or dictated message will be mailed or distributed to his/her legal representative, and that written messages will be unopened and uncensored. 12.1 also describes that dictated messages will not be censored or be opened once the message has been completed for delivery. Policy 18.2 on page two (2) describes the agency's procedures for allowing a resident to call their attorney at any time that does not interfere with the juvenile's schedule activities and is at a reasonable hour. In addition, Policy 18.3 explains that attorney and clergy may visit their clients at any time.

Furthermore, Policy 18.2 and 18.3 outline the agency's procedures for providing residents with reasonable access to parents or legal guardians. It should be noted that per 18.2, the agency provides a resident immediately upon admission two telephone calls to their parents, legal guardian, foster parent, custodians, minister, or attorney. Each resident is also able to make at least one (1) phone call every seven (7) days. If a juvenile is unable to complete the call on the first attempt, further attempts shall be afforded within reason. The number of calls

available each week can increase with the juvenile's advancement in the level system. In addition, Policy 18.3 on page one (1) states, "The facility administration encourages juveniles to maintain ties with their parents, guardians, and/or family through regular visits that are limited only by staff demands and the availability of visiting facilities. Visiting hours are established to make times available for all juvenile's parents to visit. The number of visits will be determined by the juvenile's privilege level. Each visit will be twenty (20) minutes in duration and each juvenile will be afforded at least two (2) visits per seven (7) calendar days."

The Detention Superintendent advised the auditor during his interview that a resident's attorney can contact their client over the phone or meet with him/her at the facility. Also, the Superintendent explained that a resident can also request to talk with his/her attorney, and the facility will contact the attorney for the resident. He described the visitation and phone call process that the MRJJC adheres to, and this included a minimum of two visits per week and higher level residents can have more visits, depending on the level. Phone call procedures included a minimum of two calls per week to a parent or guardian, with increase call availability for residents who earn higher levels.

Additionally, TAC §343.356 requires that residents shall be permitted reasonable confidential contact with the resident's attorney and their designated representatives through telephone, uncensored letters, and personal visits. Furthermore, TAC 343.352 (a-b) and TAC 343.538 provides for the residents' rights to receive visits from their parents or legal guardians as well as to complete telephone calls.

The auditor also interviewed eleven randomly selected residents who all explain that the MRJJC provides them with reasonable and confidential access to their attorneys or other legal representatives and reasonable access to parents and guardians. Residents were aware that they could talk privately and confidentially with their attorney, and that they could request to talk to their attorney by letting staff know. Additionally, each resident interviewed explained the parent/guardian phone call and visitation rules that included a minimum of one call per week and two visits per week, with more visits and calls made available depending on level.

Lastly, it should be noted that the Policy 18.2 explains that the juvenile's JPO provides parents a copy of the parent brochure, which covers the agency's procedures of mail, telephone, and visits of residents in the MRJJC.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.354 Third-party reporting

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.354

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 12.5 (Sexual Abuse & Mistreatment) / Last updated: 09/02/2016
- Agency website (https://co.jefferson.tx.us/juvenile/Main.htm)
- Information for Parents, Guardians and Custodians regarding: Prison Rape Elimination Act (PREA)

Explanation of determination:

115.354:
Policy 12.5 on page 3 outlines the agency's responsibilities of accepting third party reports of resident sexual abuse (i.e., reports from other juveniles, staff members, family members, attorneys, and outside advocates). Additionally, the agency also receives TJJD Incident Reporting Center (IRC) Complaint Summary Reports for any call made to the TJJD Hotline from the MRJJC. The auditor also verified that the agency published the requirements of this PREA standard on their website, in which the information is included on the agency's "Information for Parents, Guardians and Custodians regarding: Prison Rape Elimination Act (PREA)" form. This form includes the following information, as related to this PREA provision:

- Third parties (parents, attorneys, counselors, etc.) have the right to report incidents (or suspicions) of sexual abuse and sexual harassment on behalf of residents of the Jefferson County Juvenile Probation Department (JCJPD). Third party reports can be made to JCJPD staff, to the Texas Juvenile Justice Department, or to the Jefferson County Sheriff's Department.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.361 Staff and agency reporting duties

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.361

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 12.5 (Sexual Abuse & Mistreatment) / Last updated: 09/02/2016

Interviews:

- Random Sample of Staff (JSOs)
- Medical Staff (contracted nurse)
- Mental Health Staff (fulltime MHP)
- Superintendent (PREA Coordinator- PC)

Explanation of determination:

115.361 (a):
Policy 12.5 on page 4 states that MRJJC staff are required to report immediately and according to departmental policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in the department, retaliation against juveniles or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Additionally, it should be noted that 12.5 on page 2 states that any department employee, volunteer, or contractor who has cause to believe that a juvenile in any program or facility under the department's jurisdiction has been or may be subjected to an act or threat of sexual abuse and sexual harassment or receives a report of sexual abuse or possible sexual abuse and sexual harassment, whether verbally or in writing, anonymously, and from third parties must immediately notify the proper authorities in accordance with department policy, TJJD Standards, and state law.

The PC advised the auditor that the contact information for the local law enforcement with jurisdiction (Jefferson County Sheriff's Department- JCSD) and TJJD are provided to all employees, volunteers, interns, and contractors; and that JCSD's and TJJD's information is also posted in the intake rooms should staff need to make a report at any time an allegation is disclosed to them.

Additionally, the auditor interviewed 12 randomly selected JSOs who all clearly explained that the JCJPD requires all staff to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Furthermore, each staff member provided the auditor with a description of how they would report an outcry of sexual abuse or sexual harassment made, which included first-responder duties, reporting

requirements, and department procedures related to responding to a resident allegation of abuse or harassment.

It should be noted that TAC 358.200 requires all departments, programs, and facilities in Texas to have written policies and procedures that require, in accordance with this chapter:
- reporting allegations of abuse, neglect, or exploitation or the death of a juvenile to local law enforcement, TJJD, and other appropriate governmental units; and
- reporting serious incidents to TJJD.

TAC 358.300 requires the MRJJC to adhere to the following procedures related to this PREA provision:

Duty to Report.
An employee, volunteer, or other individual working under the auspices of a facility or program must report the death of a juvenile or an allegation of abuse, neglect, or exploitation to TJJD and local law enforcement if he/she:
- witnesses, learns of, or receives an oral or written statement from an alleged victim or other person with knowledge of the death of a juvenile or an allegation of abuse, neglect, or exploitation; or
- has a reasonable belief that the death of a juvenile or abuse, neglect, or exploitation has occurred.

115.361 (b):
Policy 12.5 on page 4 states that all MRJJC staff are required to comply with any applicable mandatory reporting laws.

Additionally, upon review of Texas Family Code Chapter 261.103, the auditor determined that the agency is in compliance with this PREA provision. The language below is from the TX Family Code, and it should be noted that "Department" means the Department of Family and Protective Services.
Sec. 261.103. REPORT MADE TO APPROPRIATE AGENCY.
Except as provided by Subsections (b) and (c) and Section 261.405, a report shall be made to:

- any local or state law enforcement agency;
- the department; or
- the state agency that operates, licenses, certifies, or registers the facility in which the alleged abuse or neglect occurred.

The auditor interviewed 12 randomly selected JSOs who each provided a clear explanation of the mandatory child abuse reporting requirement of reporting sexual abuse or sexual harassment to local law enforcement (JCSD) and TJJD.

115.361 (c):
Policy 12.5 on page 4 provides for the requirements of this provision and states, “apart from reporting to designated Supervisors or officials and designated State or local service agencies, staff shall be prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in departmental policy, to make

treatment, investigation, and other security and management decisions." Additionally, Policy 12.5 on page 13 states that information concerning the identify of a victim reporting sexual abuse, and the facts of the report itself, will be limited to those who have a need to know in order to make decisions concerning the juvenile's welfare and for law enforcement and TJJD investigative purposes.

The auditor's interviews with the 12 randomly selected staff (JSOs) indicated that staff are aware of the agency's confidentiality procedures, and staff advised that they would only share sensitive information regarding an allegation of sexual abuse to supervisory staff, administrative staff involved in the investigation, mental and medical health staff as appropriate for applicable treatment, and law enforcement officials involved in the investigation.

115.361 (d):
Policy 12.5 on page 4 outlines the requirements of this provision, and states that medical and mental health practitioners are required to report sexual abuse to designated supervisors and officials pursuant to this section, as well as to the designated State or local service agency where required by mandatory reporting laws {as indicated above explanations- 115.361 (a) & (b)}.

The contracted nurse was interviewed by the auditor during the onsite visit, and she explained that each resident is notified that their medical information remains confidential, and they have access to the limitations of confidentiality and the duty to report during each medical visit. Additionally, the nurse advised that she is required to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment to a designated supervisor or official immediately upon learning of it. She explained that she has never been made aware of a resident in the MRJJC as being a victim of sexual abuse or sexual harassment, but she was able to clearly articulate the appropriate protocols for ensuring a victims safety and reporting such an incident.

The auditor also interviewed the agency's Mental Health Provider (MHP), who explained that every resident is explained the limits of confidentiality and ensure they understand the limitations. Additionally, the MHP advised the auditor that if she is made aware that a resident is a victim of sexual abuse, sexual harassment, or even at risk of either; that she would immediately ensure the child's safety and advise the PC, detention supervisor, and contact law enforcement and Child Protective Services (CPS). The MHP advised that she has been made aware of a child who reported sexual abuse or sexual harassment, and she explained the required first responder and reporting duties. It should be noted that the MHP advised the auditor that she is contacted at any time a resident makes an outcry of sexual abuse or sexual harassment and for any resident admitted whose intake indicates they are a victim of sexual abuse or sexual harassment in order to assess the child's mental state and ensure all the proper services are provided.

115.361 (e):
Agency Policy 12.5 on page 13 outlines the requirements of the provision, and states that the Detention Superintendent (Head of the Facility, also the PREA Coordinator- PC) will notify the head of the facility or appropriate office of the agency where the alleged abuse occurred and shall also notify TJJD as soon as possible but no later than 72 hours after receiving the

allegation. Additionally, 12.5 on page 5 describes the agency's procedures of notifying the victim's parents or guardian of the report of sexual abuse; if the juvenile is under custody of CPS (child welfare), the report shall be made to the applicable CPS caseworker. Furthermore, if the juvenile court retains jurisdiction over the alleged victim, the Detention Superintendent or designee shall report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation.

The PC advised the auditor during his Superintendent interview that if the MRJJC receives an allegation from another facility that an incident of sexual abuse or sexual harassment occurred in the facility, he would immediately ensure the victims safety (ensuring the alleged staff member is placed on leave), initiate an investigation, notify the proper law enforcement authorities, follow the first-responder protocols as outline in agency policy, notify mental and medical health as appropriate, and notify the victim's parents and attorney.
115.361 (f):
Policy 12.5 explains that the department shall ensure that an administrative investigation is completed for all allegations of sexual abuse and sexual harassment. Additionally, 12.5 on page 2 states that any department employee, volunteer, or contractor who has cause to believe that a juvenile in any program or facility under the department's jurisdiction has been or may be subjected to an act or threat of sexual abuse and sexual harassment or receives a report of sexual abuse or possible sexual abuse and sexual harassment, whether verbally or in writing, anonymously, and from third parties must immediately notify the proper authorities in accordance with department policy, TJJD Standards, and state law. Upon review of policy 12.5 by the auditor and in conversations with the PC and Casework Manager, the auditor determined that the proper authorities, as indicated in 12.5 includes the PREA Coordinator (Superintendent of the MRJJC) and the Chief of the JCJPD. Additionally, Policy 15.12 on page one describes that in the event of an allegation of sexual abuse or sexual harassment, the staff member who receives the allegation shall inform the Chief Probation Officer or designee. Furthermore, it should be noted that Policy 15.12 on page 2 explains that an investigation of sexual abuse and sexual harassment shall be conducted promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports. This Policy also states that the Chief Juvenile Probation Officer, Juvenile Casework Manager, Detention Superintendent (PC), and two Detention Casework Supervisors are authorized to conduct sexual abuse investigations.

Additionally, it is important to note that each of the 12 randomly selected JSOs and the MHP and contracted nurse advised during their interviews that they would immediately notify their supervisor and/or the Detention Superintendent (PC) of any report of a resident sexual abuse or sexual harassment that occurred in the facility.

Lastly, the PC explained that approximately eight (8) years ago he received an allegation from a contracted resident's attorney (a third party) of the attorney's client (MRJJC resident) reporting being sexually abused while at the MRJJC. The PC advised that he immediately initiated a full investigation and notified TJJD and law enforcement. The PC explained that a review of the surveillance video from the alleged timeframe clearly disproved the resident's allegation and no such abuse ever occurred.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined

that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.362 Agency protection duties

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.362

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 12.5 (Sexual Abuse & Mistreatment) / Last updated: 09/02/2016

Interviews:

- Agency Head (Director)
- Superintendent (PREA Coordinator)
- Random Staff

Explanation of determination:

115.362:
Agency Policy 12.5 on page 4 explains that after receiving an emergency report alleging a juvenile is subject to a substantial risk of imminent sexual abuse, the department shall immediately forward the report (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, shall provide an initial response within 48 hours, and shall issue a final departmental decision within 5 calendar days. The initial response and final departmental decision shall document the department's determination whether the juvenile is in substantial risk of imminent sexual abuse and the action taken in response to the emergency report. Additionally, it should be noted that 12.5 on page 2 states that any department employee, volunteer, or contractor who has cause to believe that a juvenile in any program or facility under the department's jurisdiction has been or may be subjected to an act or threat of sexual abuse and sexual harassment or receives a report of sexual abuse or possible sexual abuse and sexual harassment, whether verbally or in writing, anonymously, and from third parties must immediately notify the proper authorities in accordance with department policy, TJJD Standards, and state law.

The agency reported in this section of the PAQ that they had zero number of times the facility or agency has determined that a resident was subject to a substantial risk of imminent sexual abuse.

The auditor interviewed the Chief of JCJPD who explained that when the agency or facility learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident. The action taken involves separating the victim from the alleged threat, and if necessary, the residents involved may be placed in isolation in order to ensure the safety and security of the residents in the facility. The Chief advised that a resident at risk may be placed in a Protective Isolation (PI) as a last resort, while still maintaining all the required activities of the detention program. The Chief advised that he must

approve all PI's, and applicable 24 hour reviews are required to be conducted by the Facility Superintendent (PC). The Chief also described that the expectation for how quickly staff should respond to protect residents at substantial risk of imminent sexual abuse is to take immediate action.

The Detention Superintendent (PC) advised the auditor during his interview that staff are required to take immediate action to an allegation that a resident is at imminent risk of substantial sexual abuse and that a POD group can be modified to ensure safety and security of the resident. Additionally, the PC explained that as a last resort, the MRJJC can place a child at risk of substantial abuse in a Protective Isolation, and if a resident is found to be involved in the threat as the aggressor, this resident can be placed on a disciplinary (seclusion) isolations in order to isolate the threat away from other residents.

Lastly, the auditor interviewed 12 randomly selected JSOs who all clearly explained that they would take, and are required to take, immediate action to prevent a resident who is subject to a substantial risk of imminent action to protect the resident. The action taken was explained as ensuring the first-responder duties are adhered to, such as: separating the victim from the threatening situation or person, advise a detention supervisor of the threat (report), and document the incident on an incident report.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.363 Reporting to other confinement facilities

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.363

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 12.5 (Sexual Abuse & Mistreatment) / Last updated: 09/02/2016

Interviews:

- Agency Head
- Detention Superintendent (PREA Coordinator/PC)

Explanation of determination:

115.361 (a-d):
Agency Policy 12.5 on page 13 outlines the MRJJC's procedures of the PC notifying the head of the applicable facility or appropriate office upon receiving an allegation that a juvenile was sexually abused while confined at another facility. Additionally, this policy explains that the PC must also notify TJJD as soon as possible but no later than 72 hours after receiving the allegation. The PC is also required to retain documentation that the notification was provided, per Policy 12.5. Furthermore, it should be noted that the notification made by the MRJJC to TJJD, helps to ensure that the agency where the alleged sexual abused occurred is being investigated by an outside law enforcement agency. Policy 12.5 on page 7 also states that the department (MRJJC) shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment (including reports made by other agencies or facilities- third parties), and the investigative procedures outlined in this policy adhere to all applicable investigative provisions required by PREA, as explained in standards explanations for §115.322 and §115.371.

The agency reported in this section of the PAQ that they had zero allegations in the past 12 months that a resident was abused while at another facility, and zero allegations of sexual abuse the MRJJC received from other facilities.

The auditor interviewed the Chief of the JCJPD who explained that the PC is the designated point of contact for all sexual abuse or sexual harassment reports made in the MRJJC or made to the MRJJC from outside agencies, facilities, or third parties. For all allegations that allegedly occur in the MRJJC, the Jefferson County Sheriff's Department (JCSD) would be immediately contacted and initiated the criminal investigation, as well as TJJD.

The PC advised the auditor during his interview that it was reported to the MRJJC from an outside source (another agency, facility, or third party) that a resident was sexual abused or sexually harassed while in the MRJJC, the PC would take immediate action to ensure resident safety. The procedures described to be taken included: initiating first-responder duties,

immediately investigate to determine who the alleged victim and perpetrator is, secure the area where the alleged abuse occurred, if a staff member is involved- place staff on administrative leave until further notice, relocate or modify the detention groups to ensure the victim and other residents are safe and away from the alleged perpetrator, and ensure all contacts are made with JCSD and TJJD, and ensure the administrative and criminal investigation is initiated. The PC explained that approximately eight (8) years ago he received an allegation from a contracted resident's attorney (a third party) of the attorney's client (MRJJC resident) reporting being sexually abused while at the MRJJC. The PC advised that he immediately initiated a full investigation and notified TJJD and law enforcement. The PC explained that a review of the surveillance video from the alleged timeframe clearly disproved the resident's allegation and no such abuse ever occurred.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.364 Staff first responder duties

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.364

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 12.5 (Sexual Abuse & Mistreatment) / Last updated: 09/02/2016

Interviews:

- Security Staff First Responders
- Non-security Staff First Responders (Medical and Mental Health staff)
- Random Sample of Staff

Explanation of determination:

115.364 (a):
The agency's first-responder policy for responding to allegations of sexual abuse, Policy 12.5, includes the provision requirements of this PREA standard. The procedures outlined in 12.5 include, but are not limited to: separate the alleged victim and abuser, preserve and protect any crime scene until the JCJPD is on scene to process the criminal investigation, and request the alleged victim and perpetrator to not do anything that could destroy physical evidence (including all the requirements pursuant to this provision).

The agency reported in this section of the PAQ that they had zero incident in the past 12 months related to an allegation that a resident was sexually abused.

The auditor interviewed a JSO who has been trained in the agency's first-responder duties who advised of the required procedures for responding to an allegation of sexual abuse. This officer clearly provided the steps that should be taken as a first-responder, to include: ensuring the safety of the victim takes priority, preserve any evidence, mark off scene to protect evidence, ensure the victim is in a safe place and comfortable, instruct the victim and perpetrator to not do anything such as shower, go the restroom, change out, cleanup, or anything that can destroy physical evidence.

The auditor also interviewed 12 randomly selected staff (JSOs) who all were able to clearly articulate the first-responder duties that are documented in Policy 12.5. Each staff member was aware of how to ensure the safety of the victim by separating the victim from the perpetrator, reporting the incident to a detention supervisor, the PC, and the proper authorities, and advising the victim and perpetrator to not do anything that could destroy physical evidence. Additionally, it should be noted that the randomly selected staff and the PC advised the auditor that they have holding room that do not include a sink or toilet, and these rooms can be used to ensure the victim and perpetrator do not take any action that could destroy physical evidence.

115.364 (b):
Policy 12.5 on page 6 states that if the first responder is not a JSO, the responder is required to request that the alleged victim not take any actions that could destroy physical evidence and then notify a JSO.

The agency reported in this section of the PAQ that they had zero incidents that alleged a resident was sexually abused in the past 12 months; therefore, they also had zero incidents of a non-security staff member acting as a first responder.

The auditor interviewed the contracted nurse and the fulltime MHP who both advised that the procedures they would take if a resident reports being a victim of sexual abuse, in which both explained they would first ensure the victim is safe, immediately notify a detention supervisor or the Detention Superintendent, contact CPS, law enforcement, and TJJD, advise the victim and perpetrator to not do anything that could destroy physical evidence, and await further instructions from the Superintendent or supervisor.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.365 Coordinated response

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.365

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 12.5 (Sexual Abuse & Mistreatment) / Last updated: 09/02/2016

Interviews:

- Detention Superintendent (PC)

Explanation of determination:

115.365:
Agency Policy 12.5 on pages 5-7 outline the MRJJC's actions taken in response to an allegation of sexual abuse or sexual harassment, pursuant to the requirements of this PREA standard. Upon review of the agency's written institutional plan, Policy 12.5, the auditor determined that the plan includes coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership.

The auditor interviewed the Detention Superintendent (PC) who explained that agency leadership, including himself, would coordinate to ensure the victim of sexual abuse is safe, separated from the alleged perpetrator, ensure an internal investigation has been initiated and that law enforcement has been notified (as well as TJJD), ensure the victim is provided the necessary medical and mental health care services (would be in contact with the agency's MHP, victim advocates, and the agency's contracted medical team), and with oversight from the Chief of the Department- ensure the investigation stays on track and make periodic status checks with law enforcement. The PC explained that the agency leadership would contact the Jefferson County Sheriff's Department and the Garth House to schedule a SANE exam at either Saint Elizabeth Hospital or Baptist Hospital, notify the Rape Crisis Center and Garth House to ensure an advocate is assigned to the victim and is with the youth through the process.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.366 Preservation of ability to protect residents from contact with abusers

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.366

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 12.5 (Sexual Abuse & Mistreatment) / Last updated: 09/02/2016

Interviews:

- Chief of the Department

Explanation of determination:

115.366:

The agency reported in this section of the PAQ that the MRJJC or any other governmental entity responsible for collective bargaining have never entered into a collective bargaining or other agreement. The Chief of the JCJPD confirmed this statement during his interview with the auditor.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.367 Agency protection against retaliation

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.367

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 12.5 (Sexual Abuse & Mistreatment) / Last updated: 09/02/2016
- Agency Policy 16.2 (Admission Procedures) / Last updated: 0616/2016

Interviews:

- Chief of the Department
- Detention Superintendent
- Designated Staff Member Charged with Monitoring Retaliation

Explanation of determination:

115.367 (a):
The agency provided the auditor with Policy 12.5 which includes on page 5 procedures to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigation from retaliation by other residents or staff. The agency advised the auditor and it is stated in 12.5 that the Detention Superintendent (who is also the PREA Coordinator/PC) or his designee is the designated staff member in charge of monitoring for possible retaliation. Furthermore, this policy states that retaliation against any juvenile or employee who reports or assists in the investigation of alleged sexual abuse and sexual harassment is strictly prohibited and is grounds for disciplinary action up to and including termination of employment.

115.367 (b):
Policy 12.5 on page 5 indicates that the agency employs multiple protective measures for juveniles or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with an investigation, to ensure that retaliation does not occur. Such measures included in 12.5 include: reclassification or transfer for juvenile victims or abusers, removal of alleged staff or juvenile abusers from contact with victims, and emotional support services. Furthermore, agency Policy 16.2 includes classification procedures that are taken into consideration when reclassification occurs in order to ensure the child being moved (reclassified) is not placed in a location that is detrimental to his/her safety.

The auditor interviewed the Chief of the JCJPD who advised that the agency ensures the protection of resident and staff from retaliation for sexual abuse or sexual harassment allegations by training and making staff aware of their responsibilities and rights related to retaliation (including what and how to report), closely monitoring the resident who is involved in a sexual abuse or sexual harassment allegation to ensure his/her safety at all times, and ensure residents are aware of their right to be free from retaliation and the methods in place

to report.

The auditor also interviewed the Detention Superintendent (who is also the PC) who advised that for allegations of sexual abuse or sexual harassment, the following measures are taken to protect residents and staff from retaliation:

- Meet with the Detention Supervisors at least once a week to discuss how the resident is being protected, review the resident's level, and communicate with the resident and ask if there are any issues or safety concerns to immediately address.
- Review the child's daily point sheet (Detention Supervisors do this once a week for all residents).
- Modify the POD grouping or reclassify residents as needed to ensure safety and protection from retaliation.
- Review disciplinary logs.
- Any resident who reports sexual abuse or sexual harassment against a staff member, regardless if unfounded or unsubstantiated, will not be assigned to supervise the resident who made the allegation throughout the resident's stay in detention.
- Victim services and the agency's MHP would be consulted and any concerns would be staff by the counselor and the Detention Superintendent.

115.367 (c):
Policy 12.5 on page 5 explains that the agency monitors the conduct or treatment of juveniles or staff who report sexual abuse and of juveniles who were reported to have suffered sexual abuse for at least 90 days, to determine if there are changes that may suggest possible retaliation by juveniles or staff. Additionally, 12.5 states that immediate action shall be taken to remedy any retaliation, and that the agency continues monitoring beyond 90 days if the initial monitoring indicates a continuing need.

The agency reported in this section of the PAQ that they had zero incidents involving retaliation that occurred in the past 12 months.

The PC explained to the auditor that if he suspects any retaliation occurring in the facility, he would immediately take action and investigate to ensure the victims safety. Such measures to protect the victim of suspected or actual retaliation include: if a resident is involved in the retaliation as the retaliator, the resident would be placed in a disciplinary seclusion (isolation); if the retaliator is a staff member, this staff would be immediately suspended and not allowed access into the facility- pending full investigation.

The auditor also interviewed the PC as a staff member who is in charge with monitoring retaliation, and he advised that retaliation monitoring includes talking with the resident victim at least weekly; monitoring resident behavior levels; and review disciplinary reports, detention hearing information, incident reports, and staff disciplinary reports. Additionally, the PC advised that he would monitor for retaliation for the entire stay the resident is in detention.

115.367 (d):
The agency's PC, who is also the Detention Superintendent and the designated staff member who is in charge of monitoring for retaliation, stated in his interview that he would monitor for retaliation for the entire resident's detention stay, and that he would periodically check in with

the resident victim (face-to-face meeting) weekly (or more frequently if needed) to ensure the resident is safe and free from any type of retaliation.

The Chief of the JCJPD advised the auditor during his interview that if an individual who cooperates with an investigation expresses fear of retaliation, he would ensure action is taken to protect the individual by possibly modifying the resident's POD group, moving residents while remaining compliant with the procedures provided in the classification policy (reclassification), and ensure the victim is located in a safe place away from the suspected retaliator.

115.367 (e):
Policy 12.5 on page 5 states that if any other individual who cooperates with an investigation expresses a fear of retaliation, the department shall take appropriate measures to protect the individual against retaliation.

115.367 (f):
N/A. The auditor is not required to audit this provision. Although, it should be noted that the PC advised the auditor that any resident who reports sexual abuse or sexual harassment against a staff member, regardless if unfounded or unsubstantiated, will not be assigned to supervise the resident who made the allegation throughout the resident's stay in detention.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.368 Post-allegation protective custody

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.368

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 9.15 (Seclusions) / Last updated: 06/16/2016
- Facility Protective Isolation Request/Authorization form
- Facility Protective Isolation Log
- 14 Disciplinary Seclusion Repots (randomly selected by the auditor)
- Texas Administrative Code 343.290 (Protective Isolation)

Interviews:

- Detention Superintendent (PREA Coordinator/PC)
- Staff (JSO) who Supervises Residents in Isolation
- Medical and Mental Health Staff

Site Review Observations:

During the onsite audit, the auditor did not observe a resident isolated in his/her room on a Protective Isolation.

Explanation of determination:

115.368
Agency Policy 9.15 on page 4 outlines the agency's Protective Isolation (PI) procedures, and it should be noted that the agency utilizes Protective Isolation when a juvenile is physically threatened by another juvenile or a group of juveniles (i.e., risk of sexual victimization) and less restrictive measures are inadequate to keep the juvenile safe. Per Policy 9.15, "during the isolation period, the department shall not deny the juvenile daily large-muscle exercise and any legally required educational programming or special education services. Juveniles in isolation shall receive daily visits from the Mental Health Practitioner (MHP) or Medical Staff and shall have access to other programs and work opportunities to the extent possible." Additionally, Policy 9.15 describes the review process for continuing a PI past 24 hours, which includes the following procedures: "After the initial 24 hours and every 72 hours thereafter, the Detention Superintendent or designee shall conduct a documented review of the circumstances surrounding the level of threat faced by the juvenile and make a determination whether the PI should continue or whether less protective restrictions can take place. However, if PI is to be continued, the Superintendent or designee shall ensure that review documentation includes an alternative service delivery plan to ensure that the resident is afforded the required program services while in PI."

Additionally, the auditor reviewed the agency's PI Request/Authorization form, which provides

an example of how the agency documents placing a resident on PI. The form includes a space for the resident's name, date/time, room number, who the PI request is against (the threat), narrative/reason for isolation, staff signature, who authorizes, observations made, etc. The agency also provided the auditor with their PI log, which documents any resident placed on PI, the date of isolation request and date of isolation, reason, and date of removal from isolation.

The agency reported in the PAQ that they had zero resident's placed on any type of isolation who were deemed at risk of sexual victimization or alleged to have suffered sexual abuse in the past 12 months, and the auditor was able to verify this by reviewing the PI log and interviewing the Superintendent, a staff who supervises residents in isolation, the MHP, and a contracting nurse (as explained below). Additionally, the Auditor reviewed 14 randomly selected disciplinary seclusion reports from the past 12 months in order to verify that the facility has not placed a resident in a seclusion for an incident of alleged sexual abuse or sexual harassment, and each report reviewed did not indicate a resident being involved in such an incident.

The Superintendent advised the auditor during his interview that residents are only isolated from others 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. He explained that he has never had to place a child on a Protective Isolation for being at risk of sexual victimization, and that if a child deemed to be at such a risk, the agency is able to modify the PODs to house a resident in a small group (i.e., 2 to 3 residents) to ensure safety. The Superintendent also clarified how each PI would be reviewed by administration before being initiated, that the Chief would make the final approval, and that the PI would then be reviewed daily (every 24 hours) until the child is removed off the PI.

A staff member who supervises residents in isolation was interviewed by the auditor, and he described the facility's process of placing a child on a PI. This officer explained that a resident on a PI would have access to programs, privileges, education/special education, and work opportunities. He also stated that a resident who is placed on a PI would only be placed in isolation until an alternative means of separation from the likely abuser or threat can be arranged, and that in most cases, a modified group can be quickly arranged to eliminate the need of isolating due to a safety concern or threat. The officer stated that he has never been involved in a situation involving a resident being placed on PI (over 20 years of working in the facility), and explained that if such an incident occurred, the resident would only be kept in isolation until alternative means of keeping the resident safe could be implemented. He provided information that the PI would be reviewed by administration every 24 hours, and that medical and mental health staff would never be turned away for a resident in a PI.

The agency's MHP was interviewed by the auditor and confirmed that mental and medical health staff are able to visit with residents in isolation every day. It was explained that a resident has never been placed in a Protective Isolation for being at risk of sexual abuse (as far as she was aware) and that the MHP does routinely check on residents in their room (i.e., serving a disciplinary seclusion) just to check in and ensure the resident is ok.

The agency's contracted registered nurse explained to the auditor during her interview that mental and medical staff routinely conduct visits with residents, regardless of if a resident is in a secure room or not. Additionally, it was explained that a resident has never been placed in a

Protective Isolation for being at risk of sexual abuse (as far as she knew) and that all residents are able to visit with a medical or mental health practitioner if needed and as required.

The Casework Manager explained that if a situation occurred that the Facility places a resident on PI for being at risk of sexual victimization, the Agency would work out a schedule for the MHP and/or one of the contracting nurses to visit the resident on PI every day, even if it is not their regular scheduled day. The MHP is able to flex her time elsewhere as needed or earn comp time to be utilized at a more convenient time, or the nurse would be compensated for the time they entered the facility to see the resident. The Casework Manager also described how the Agency can contact a Qualified Mental Health Provider (QMHP) from Spindletop Services to counsel with the resident if needed.

Additionally, it should be noted that Texas Administrative Code 343.290 (Protective Isolation) requires the agency to adhere to the following guidelines when placing a child on PI:

- Protective isolation may be used as a last resort only when:
- a resident is physically threatened by a resident or a group of residents;
- less restrictive measures are inadequate to keep the resident safe; and
- the decision is approved in writing by the facility administrator.

Protective isolation may be used only until alternative means for keeping the resident safe can be arranged.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.371 Criminal and administrative agency investigations

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.371

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 12.5 (Sexual Abuse & Mistreatment) / Last updated: 09/02/2016
- Agency Policy 15.12 (Notification and Reporting Illness, and Investigating Abuse, Exploitation or Death / Last updated: 06/16/2016

Interviews:

- Investigative Staff (Detention Superintendent/PC)
- Casework Manager

Site Review Observations:

During the onsite audit, the auditor reviewed the agency's last sexual misconduct investigation that was conducted in 2016. The agency reported to the auditor that this 2016 investigation was the latest sexual type allegation reported, and it should be noted that this investigation involved alleged staff sexual misconduct toward a resident (as detailed in this standard explanation of determination). It was reported to the auditor by the PC that there was one targeted resident in the current detention population that reported on the agency's Behavioral Screen (Risk Screening) of being a victim of sexual abuse while in the community. During the onsite visit, the agency did not report to the auditor of a resident who reported sexual abuse that allegedly occurred in the facility (MRJJC), and therefore the auditor did not have the opportunity to interview such a resident. The auditor also verified that no such resident was currently in the facility who reported sexual abuse that allegedly occurred in a facility through conducting a total of 11 resident interviews (11 out of a possible 13 available residents while the auditor was onsite). Each resident advised during their interview that they were not a victim of sexual abuse that occurred in the facility.

Explanation of determination:

115.371 (a):
Agency Policy 12.5 on page 7 outlines the agency's requirements to ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. The JCJPD conducts administrative investigations, and the Jefferson County Sheriff Department is required to conduct criminal investigations. Additionally, Policy 12.5 on page 2 explains that all allegations of sexual abuse or sexual harassment involving a juvenile shall be immediately referred to the Jefferson County Sheriff's Department (JCSD) and Texas Juvenile Justice Department (TJJD). Additionally, Policy 15.12 on page 3 states that administrative investigations of sexual abuse or sexual harassment shall be conducted promptly, thoroughly, and objectively for all allegations, including third-party and anonymous

reports.

The PC, who is one of the agency's specially trained administrative investigators, advised during this interview that all administration investigations will be immediately initiated upon a report of sexual abuse or sexual harassment. Additionally, he explained that the Jefferson County Sherriff's Department (JCSD) would be contacted immediately to conduct the criminal investigation, and that a law enforcement officer from the JCSD would at the MRJJC with 5 minutes of the call (their Department is next door the MRJJC). The PC also advised that TJJD would be immediately notified, and TJJD assigned investigator would be in contact with the facility.

115.371 (b):
Policy 15.12 on page 3 states that the Chief Probation Officer (Director of JCJPD), Juvenile Casework Manager, Detention Superintendent (PREA Coordinator), and two Detention Casework Supervisors are authorized to conduct sexual abuse investigations and shall receive training in conducting such investigations in confinement settings. The Policy also states that specialized training shall include 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. Additionally, 15.12 on page 3 states that the department shall maintain documentation that department investigators have completed the required specialized training in conducting sexual abuse investigations.

The agency provided the auditor with Department of Justice Certification of Completion documents for each of the agency administrative investigators and the corresponding curriculum from the training. The Certificates state that each investigator was trained on "PREA: Investigating Sexual Abuse in a Confinement Setting," and that the training was presented by the National Institute of Corrections (3 hour training). The training curriculum provided breaks down the training into three (3) chapters with multiple sections in each chapter, including the following training topics:
- Taking the Course, General Investigative Protocols, The Allegation, Initial Response, Evidence Collection and Preservation, Interviews and Interrogations, Non-Witness Interviews, Review of Past Reports and Records, and Determination of Findings.

The auditor interviewed the Detention Superintendent, who is also the PREA Coordinator (PC) and an administrative investigator for the agency, and he explained that he has completed two different investigative trainings- one with TJJD and one online with the Department of Justice (as described above). The PC explained his responsibilities for conducting an administrative investigation to include: ensuring the victim is safe and separated from the perpetrator; preserving video evidence; document who was involved; investigate for any deviations to schedule; review log books and other related documentation; interview witnesses, victim, and perpetrator (asking open-ended questions as applicable); ensure the JCSD and TJJD has been contacted; and cooperate and remained informed with the criminal investigation. The PC was able to clearly articulate the training materials provided during the two trainings he completed, to include the investigative protocols as described above, techniques for interviewing juvenile sexual abuse victims, the 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

(preponderance of evidence for administrative investigations).

115.371 (c):

Policy 15.12 on page 3 outlines that the investigators and/or law enforcement shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic data; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator.

The PC, who is an administrative investigator for the agency, advised that his first step in initiating an administrative investigation would be to immediately prioritize the resident victim's safety and ensure the required first-responder duties are and were adhered to. He explained that when he, or another investigator, is assigned to an investigation that the investigators only assignment is the investigation- takes priority over everything else. Additionally, the PC advised that an administrative investigation would generally take about one week to complete.

115.371 (d):
Policy 15.12 on page 3 states that the department shall not terminate an investigation solely because the source of the allegation recants the allegation.

The PC, who is an administrative investigator, advised that an administrative investigation will continue to the end, regardless if the source of the investigation is released or recants the allegation.

115.371 (e):
Policy 15.12 on page 3 states that when the quality of evidence supports prosecution, law enforcement will conduct compelled interviews, and the department will only conduct compelled interviews only after consulting with the District Attorney's office as to whether compelled interviews may be an obstacle for subsequent criminal prosecution.

The PC, who is an administrative investigator, advised that he would document in the administrative investigative report if a staff member refuses to cooperate with an investigation and provide an interview, and that he would consult with the District Attorney if compelled interviews were necessary.

115.371 (f):
Policy 15.12 on page 3 states that the credibility of the allege victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person's status as juvenile or staff, and that juveniles will not be required to submit to polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation.

The PC, who is an administrative investigator, advised that he would not take judge the credibility of an alleged victim, suspect, or witness during an administrative investigation; and that he and the agency would never require a resident who alleges sexual abuse to submit to a polygraph examination or truth telling devise as a condition for proceeding with an investigation.

115.371 (g-k):
Policy 15.12 on page 4 outlines the agency's responsibilities of conducting an administrative investigation that includes an effort to determine whether staff actions or failures to act contributed to the abuse; and shall be documented in the investigative report that includes a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. Policy 15.12 also explains that law enforcement will be responsible for criminal investigative reports that should contain a thorough description of physical, testimonial, and documentary evidence where feasible, and that substantiated allegations of conduct that appears criminal shall be referred for prosecution. Policy 12.5 on page 7 states that disciplinary action and/or filing of criminal charges on the alleged perpetrator may be imposed pending the results of the internal (administrative) and/or external (criminal) investigation. Additionally, agency Policy 12.5 on page state that all allegations of sexual abuse or sexual harassment are referred for investigation to an agency (Jefferson County Sheriff Department- JCSD) with the legal authority to conduct criminal investigation, unless the allegation does not involve potential criminal behavior. Policy 15.12 on page 4 explains that the department (MRJJC) shall retain all written reports in regards to sexual abuse and sexual harassment allegations for as long as the alleged abuser is detained (incarcerated) or employed by the agency, plus five (5) years, unless the law requires a shorter period of retention. The Casework Manager advised the auditor that if the alleged perpetrator of sexual abuse or sexual harassment is a resident, the MRJJC will receive the completed report from law enforcement (JCSD) and enter the information into the agency's system to send to the District Attorney for probable cause and follow the case from there. She also explained that if the alleged perpetrator is a staff member, and not terminated through the administrative investigation, her agency will receive a hit through the FAST system if the person is charged and follow the case from that point on until termination or dismissal depending on the circumstances. The Casework Manager also advised that her agency can access the Jefferson County adult records in their RUMBA system to follow up on cases for fail and court records. She explained that the JCJPD has a very good communication with their District Attorney's office and will cooperate with anything that they may need. Additionally, Policy 12.5 on page 7 states that all terminations for violations of department sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. With this information, the auditor determined that a criminal and administrative investigation would continue even if the alleged abuser or victim departed from the employment or control of the facility or agency.

Additionally, the auditor reviewed the most recent allegation of a sexual abuse or sexual harassment type incident, which was an allegation of staff sexual misconduct toward a resident from 2016. Per the investigative reporting documents, the alleged staff member was immediately suspended by the Detention Superintendent (PC) as soon as the report was made to the agency, the Jefferson County Sheriff's Department and TJJD were notified immediately to conduct criminal investigations, and the JCJPD initiated their own administrative investigation. The documents included in this investigative file from 2016 included the following documents:

- Policy 12.5 (Sexual Abuse and Mistreatment) and Policy 9.3 (Juvenile Supervision and

Movement)
- Documentation of the alleged sexual comment made by the staff member to the resident.
- Witness statements from staff, residents, and a volunteer.
- Grievance written by the resident victim that initiated the abuse investigation.
- Incident report from a staff member who was allegedly involved.
- Termination Documents (stating a violation of the zero tolerance policy for any form of sexual misconduct, abuse, or sexual harassment).
- An Investigative Report outlining the investigation from beginning to end.
- Disposition documentation from TJJD stating that the preponderance of evidence did not determine the incident met the statutory definition of abuse, neglect, or exploitation.
- A Case Number
- Documentation that the JCSD was contacted, but no criminal investigation was initiated due to TJJD's findings.

It should be noted that TJJD concluded in their investigation report that the preponderance of evidence did NOT determine the incident met the statutory (TX) definition of abuse, neglect, or exploitation; therefore, criminal charges were never petitioned. Furthermore, the JCJPD did contact the Jefferson County Sheriff's Department (JCSD) to report the alleged staff sexual misconduct (as required by JCJPD Policy 12.5); although, the JCSD did not conduct a full criminal investigation due to the disposition found by TJJD (per the PC). The JCJPD completed their own administrative investigation and found that the alleged staff member was in violation of Department Policies 12.5 and 9.3- zero tolerance for any form of sexual misconduct, abuse, or sexual harassment- and as a result, terminated from employment.

The agency reported in section §115.371 (i)-2 of the PAQ that they had zero substantiated allegations of conduct that appeared to be criminal that were referred for prosecution since the last PREA audit in 2016.

The PREA Coordinator (PC), who is also the Detention Superintendent and an administrative investigator for the agency, advised during his interview that the steps he takes during an administrative investigation to determine whether staff actions or failures to act contributed to the sexual abuse would include: review surveillance cameras, conduct interviews, talk to staff, and ensure that the mandatory staff to resident ratios were maintained. The PC also explained that he documents all administrative investigations on TJJD Investigation Reports and on an agency specific Internal Summary Report, and the TJJD report is submitted to TJJD within five (5) calendar days of initiating the administrative investigation. It should be noted that the TJJD Investigative Report includes the following information:

- general information {names, dates, locations, case numbers, victim(s), perpetrator(s), & witness(es)};
- law enforcement information;
- department, program, employment separation;
- witness information;
- summary of original allegation;
- relevant policy and procedure related to the alleged incident;
- written summary of all oral interviews conducted;
- list of all evidence collected;
- relevant findings;

- additional information;
- assigned disposition (unfounded, substantiated, or unsubstantiated);
- disciplinary action taken; and
- list of all staff involved in the investigation.

The PC also advised that criminal investigations are documented by the agency conducting the investigation (JCSD and/or TJJD) on their own reporting forms. He explained that he is required to refer a case for prosecution at the time the allegation is alleged by reporting to local law enforcement (JCSD) and TJJD, and that he will always continue an administrative investigation until the conclusion of the investigation, regardless if the perpetrator terminates employment prior to a completed investigation into his/her conduct. Additionally, the PC advised that he would notify the JCSD and TJJD if the alleged perpetrator terminates his/her employment or is released from detention before the criminal investigation is completed.

115.371 (l):
N/A. The auditor is not required to audit this provision

115.371 (m):
Policy 15.12 on page 3 outlines the agency's responsibility to fully cooperate with any criminal investigation (including any outside law enforcement or TJJD) involving alleged child abuse (including sexual abuse and sexual harassment), exploitation or neglect.

The Detention Superintendent, who is also the agency's PREA Coordinator (PC), explained during his interview that he is the agency's point of contact for communication involving any criminal investigation that occurs in the MRJJC. He described the process of how he would check on the status of a criminal investigation, cooperate fully with any request, and how the agency would endeavor to remain informed. The PC provided the auditor with his point of contact with the Jefferson County Sherriff's office and the District Attorney's office, a Detective for the JCSD and the County's District Attorney, and stated that he would be in contact with both individuals at least once per week. Furthermore, the PC stated that he would initially request that the detective, or any criminal investigator who is conducting an investigation in the MRJJC, to follow the applicable PREA standards, pursuant to §115.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.372 Evidentiary standard for administrative investigations

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.372

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 15.12 (Notification and Reporting Illness, and Investigating Abuse, Exploitation or Death / Last updated: 06/16/2016

Interviews:

- Investigative Staff (Detention Superintendent/PC)

Explanation of determination:

115.372:
Policy 12.12 on page 4 states that the department imposes a standard of preponderance of evidence or lower standard in determining whether allegations of sexual abuse or sexual harassment are substantiated.

The Detention Superintendent, who is also the agency's PREA Coordinator (PC), explained during his interview that a preponderance of evidence is the standard of evidence the agency is required to use for substantiating allegations of sexual abuse or sexual harassment.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.373 Reporting to residents

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.373

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 15.12 (Notification and Reporting Illness, and Investigating Abuse, Exploitation or Death / Last updated: 06/16/2016

Interviews:

- Detention Superintendent (who is also the PREA Coordinator/PC and administrative investigator)
- Casework Manager

Explanation of determination:

115.373 (a):
Agency Policy 15.12 outlines the agency's requirements of adhering to this PREA provision of notifying a victim of sexual abuse whether the allegation has been determined to be substantiated, unfounded, or unsubstantiated following an administrative investigation. The Casework Manager advised the auditor that if the allegation was received through the grievance process, the disposition would be documented on the grievance form and provided to the resident who made the allegation and that all resident's alleging sexual abuse will be notified verbally of the disposition of the administrative and criminal investigations. She explained that the method of delivering the disposition information to the resident would also be documented in the administrative investigative report. Additionally, the auditor interviewed the PC (agency administrative investigator) who advised that he was aware of the requirement of this PREA provision, and would always notify a resident who alleges sexual abuse of the outcome of both the criminal and administrative investigation.

The agency documented on the PAQ for this section that they had zero criminal and/or administrative investigations of alleged resident sexual abuse that were completed by the agency in the past 12 months.

115.373 (b):
Policy 15.12 on page 4 states the requirements of this PREA provision and states, "if the department was unable to conduct an administrative investigation in efforts to not interfere with criminal investigation, the department shall request the relevant information from law enforcement or the District Attorney's office in order to inform the juvenile."

The agency documented on the PAQ for this section that they had zero investigations of alleged resident sexual abuse in the facility that were completed by an outside agency in the past 12 months.

115.373 (c-e):
Policy 15.12 on page 4 explicitly includes the notification requirements of these PREA provisions, and the agency reported in this section of the PAQ that they have had zero substantiated or unsubstantiated complaints of sexual abuse committed by a staff member against a resident in the MRJJC in the past 12 months. Policy 15.12 states that all such notifications or attempted notifications, pursuant to this standard, shall be documented.

The agency reported in section §115.373 (e)-2 of the PAQ that they had zero incidents in the past 12 months involving notifying a resident that was involved in alleged sexual abuse or sexual harassment.

115.373 (f):
N/A. The auditor is not required to audit this provision; although, it should be noted that this PREA provision is included in Policy 15.12 on page 4.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.376 Disciplinary sanctions for staff

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.376

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 12.5 (Sexual Abuse & Mistreatment) / Last updated: 09/02/2016
- 2016 Investigative Report

Explanation of determination:

115.376 (a-d):
Policy 12.5 on page 8 explains that MRJJC staff shall be subject to disciplinary sanctions up to and including termination for violating department sexual abuse or sexual harassment policies, and that termination shall be the presumptive disciplinary sanction for staff who has engaged in sexual abuse.

The agency reported in this section of the PAQ that they have had zero incidents involving staff who have violated agency sexual abuse or sexual harassment policies in the past 12 months; and, therefore, also zero incidents involving staff from the facility who have been disciplined for violation of sexual abuse or sexual harassment policies.

Policy 12.5 also explains that disciplinary sanctions for violations of department policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) shall 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.

Additionally, Policy 12.5 on page 7 includes the requirements of provision (d) of this standard and provides for the requirement to report to JCSD for all terminations and resignations by staff involved in any violations of sexual abuse or sexual harassment policies.

Furthermore, the auditor reviewed the most recent allegation of a sexual abuse or sexual harassment type incident, which was an allegation of staff sexual misconduct toward a resident from 2016. Per the investigative reporting documents, the alleged staff member was immediately suspended by the Detention Superintendent (PC) as soon as the report was made to the agency, the Jefferson County Sheriff's Department and TJJD were notified immediately to conduct criminal investigations, and the JCJPD initiated their own administrative investigation.
It should be noted that TJJD concluded in their investigation report that the preponderance of evidence did NOT determine the incident met the statutory (TX) definition of abuse, neglect, or exploitation; therefore, criminal charges were never petitioned. Furthermore, the JCJPD did contact the Jefferson County Sheriff's Department (JCSD) to report the alleged staff sexual misconduct (as required by JCJPD Policy 12.5); although, the JCSD did not conduct a full

criminal investigation due to the disposition found by TJJD (per the PC). The JCJPD completed their own administrative investigation and found that the alleged staff member was in violation of Department Policies 12.5 and 9.3- zero tolerance for any form of sexual misconduct, abuse, or sexual harassment- and as a result, terminated from employment.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.377 Corrective action for contractors and volunteers

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.377

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 12.5 (Sexual Abuse & Mistreatment) / Last updated: 09/02/2016

Interviews:

- Detention Superintendent (PC)

Explanation of determination:

115.377 (a-b):
Agency Policy 12.5 on page 8 outlines the MRJJC's requirement of prohibiting contact with residents and reporting to law enforcement and to the applicable licensing bodies any contractor or volunteer who engages in sexual abuse, unless the activity was clearly not criminal. Additionally, 12.5 states that the department shall take appropriate remedial measures, and shall consider whether to prohibit further contact with residents, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

The agency reported in the PAQ that they have had zero incidents involving contractor or volunteers in the past 12 months who engaged in sexual abuse. Additionally, the PC confirmed during his interview with the auditor that the MRJJC is required to take remedial measures and prohibit further contact with residents in any case of any violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.378 Interventions and disciplinary sanctions for residents

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.378

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 12.5 (Sexual Abuse & Mistreatment) / Last updated: 09/02/2016
- TAC Standard 343.276 (Formal Disciplinary Reviews for Disciplinary Seclusions)

Interviews:

- Detention Superintendent (PC)
- Medical and Mental Health Staff

Explanation of determination:

115.378 (a):
Policy 12.5 on page 7 states the requirements of this provision and states, “a juvenile may be subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the juvenile engaged in juvenile-on-juvenile sexual abuse or following a criminal finding of guilt for juvenile-on-juvenile sexual abuse.

The agency reported in this section of the PAQ that the MRJJC had zero incidents in the past 12 months involving administrative findings or criminal finding of resident-on-resident sexual abuse that occurred in the facility.

The Detention Superintendent (PC) explained to the auditor that the maximum amount of time a resident can be placed in a disciplinary seclusion (isolation) for any type of major incident is 48 hours and that formal review process is required to be completed before the seclusion can begin.

The Auditor reviewed fourteen (14) randomly selected disciplinary seclusions (isolations) from the past 12 months while onsite in order to verify that the facility has not placed a resident on such a seclusion for being involved in an incident of sexual abuse or sexual harassment. Upon review, the Auditor determined that all 14 did not include an incident of sexual abuse or sexual harassment.

Additionally, it should be noted that TAC Standard §343.276 (Formal Disciplinary Reviews for Major Rule Violations Effective Date: 6/1/16) requires the MRJJC to comply with the following:
- A resident shall receive a formal disciplinary review before disciplinary seclusion is imposed unless the review is waived in writing by the resident.

115.378 (b):
Policy 12.5 on page 7 explains that any disciplinary sanctions shall be commensurate with the

nature and circumstances of the abuse committed, the juvenile's disciplinary history, and the sanctions imposed for comparable offenses by other juveniles with similar histories; and in the event a disciplinary sanction results in the isolation of a juvenile, the department shall not deny the juvenile daily large-muscle exercise or access to any legally required educational programming or special education services, daily visits from a medical or mental health care clinician, and access to other program and work opportunities to the extent possible.

The agency reported in this section of the PAQ that the MRJJC had zero incidents in the past 12 months involving a resident being placed in isolation as a disciplinary sanction for resident-on-resident sexual abuse.

The PC explained that if a resident was placed on a disciplinary seclusion (isolation) for resident-on-resident sexual abuse, the resident would be provided access large-muscle exercise, legally required education, daily visits from medical and mental health, and work opportunities.

The agency's MHP was interviewed by the auditor and confirmed that mental and medical health staff are able to visit with residents in isolation every day. The MHP explained that she does routinely check on residents in their room (i.e., serving a disciplinary seclusion for a major infraction of any kind) just to check in and ensure the resident is ok. She advised the auditor that she has never known of a resident that was placed in a disciplinary seclusion for resident-on-resident sexual abuse.

The agency's contracted registered nurse explained to the auditor during her interview that mental and medical staff routinely conduct visits with residents, regardless if a resident is in a secure room or not. Additionally, it was explained that a resident has never been placed in a disciplinary seclusion for being a perpetrator of sexual abuse (as far as she knew) and that all residents are able to visit with a medical or mental health practitioner as needed and as required.

115.378 (c):
Policy 12.5 on page 7 states that the disciplinary process shall consider whether a juvenile's mental disabilities or mental illness contributed to his/her behavior when determining what type of sanction, if any, should be imposed.

The PC explained to the auditor that the MRJJC is prohibited from placing a resident, regardless of the behavior, on a disciplinary seclusion who has been diagnosed with a serious mental illness or serious or profound intellectual disability. He also explained that all situations involving a resident-on-resident sexual abuse incident would be reviewed and the child's mental disabilities or mental illness would be considered when deciding the proper sanction to be applied, if any, and the length of time the child will be on the disciplinary seclusion, if warranted.

It should be noted that in TAC Standard §343.285, the agency is required to adhere to the following procedure related to a disciplinary seclusion:
- Disciplinary seclusion shall not be issued to a resident with a known diagnosis of:
- a serious mental illness; or
- severe or profound intellectual disability.

115.378 (d):
Policy 12.5 includes procedures for the MRJJC to provide counseling and other interventions to address and correct underlying reasons or motivations for abuse and may consider whether to offer the offending juvenile participation in such interventions. Additionally, 12.5 explains that the MRJJC may require participation in such interventions as progress through the behavior level system on a case-by-case basis.

The agency's fulltime MHP advised the auditor that she, and other counselors who volunteer with the Inspire Encourage Achieve organization, offers and conducts therapy, counseling, and other intervention services that are designed to address and correct the underlying reasons or motivations for sexual abuse. She also explained that all residents are offered counseling services and never punished for not accepting the services offered. Additionally, it should be noted for this provision, as noted in previous provision explanations of this report, that the MHP for the agency is a licensed Sex Offender Treatment Provider, and she stated to the auditor that she is currently working on her doctoral degree in psychology.

One of the agency's contracted nurses advised the auditor during her interview that her agency contracts with a psychologist who is able to visit with the residents at the facility and provide therapy and counseling to address and correct the underlying reasons or motivations for sexual abuse. The nurse also described that all resident have the right to refuse counseling and therapeutic services and will not be punished for the refusal.

115.378 (e):
Policy 12.5 on page 8 provides the requirement of this provision and states that the department may discipline a juvenile for sexual contact with staff only upon a finding that the staff member did not consent to such contact.

115.378 (f):
Policy 12.5 on page 3 outlines the requirement of this provision and states that the department prohibits any disciplinary action for a juvenile who made a report of sexual abuse in good faith.

115.378 (g):
Policy 12.5 on page 1 states that it is the rule of the department to ensure that any form of sexual activity between youth or between youth and staff/volunteers/contract employees, regardless of consensual status, is strictly prohibited.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.381 Medical and mental health screenings; history of sexual abuse

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.381

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 16.2 (Admission Procedures) / Last updated: 6.16.2016
- Agency Policy 12.5 (Sexual Abuse & Mistreatment) / Last updated: 09/02/2016
- PREA Log form (from 11/23/2015 – 2/18/2018)
- JCJPD MRJJC Intake Behavioral Screening form
- Chapter 51 of the Texas Family Code

Interviews:

- Resident who Disclosed Sexual Victimization at Risk Screening
- Staff Responsible for Risk Screening
- Mental Health Staff (MHP for the agency)
- Casework Manager
- Randomly Selected Staff (JSOs)

Site Review Observations:

During the onsite audit, the auditor met with the agency's MHP who provided documentation of her follow-up meetings with two residents- one who reported sexual abuse that occurred in the community during the intake risk screening (Behavioral Screening) and another resident whose Behavioral Screening indicated prior sexual abusiveness. The MHP provided the auditor with her log that verified the dates and times for each follow-up meeting, as explained in more detail below.

Explanation of determination:

115.381 (a-b):
Policy 16.2 on page 2 explains that if the results from the behavioral health screening form indicate that a juvenile has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, staff shall ensure that the juvenile is offered a follow-up meeting with a medical or mental health professional within 14 days of the intake screening.

Policy 16.2 on page 2 explains that if the results from the behavioral health screening form indicate that a juvenile has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, staff shall ensure that the juvenile is offered a follow-up meeting with a mental health professional within 14 days of the intake screening.

The agency provided the auditor with their Behavior Screening form that is utilized as the

agency's risk screening tool pursuant to §115.341, and it should be noted that the auditor made a recommendation of enhancement to this form to assist with demonstrating a referral of a resident to mental health. The agency added the following statement to their form and provided the updated form to the auditor after the onsite, "If yes (to prior sexual victimization/abusiveness), does the juvenile want MHP follow-up? Yes/No. This enhancement of the agency's risk screening form works in conjunction with their process of also sending the MHP a mental health referral form and contacting the MHP over the phone or in-person.

Additionally, the agency provided the auditor with their MHP's PREA Log that includes all residents she has met with due to be a victim or perpetrator of sexual abuse from 2015 to 2018. This log documents the youth's name and personal identification number, date of detention outcry, victim or perpetrator, and counseling action taken.

During the auditor's interview with the agency's MHP, the MHP provided the auditor with her documentation demonstrating the follow-up meetings she had with the residents currently in detention whose behavior screenings indicated prior victimization and prior abusiveness. For each follow-up meeting documented, the dates and times of the face-to-face meetings were within one day of the date of each resident's admission into the facility. Furthermore, the MHP also advised the auditor that she would either be contacted directly (either in-person or over the phone) or a mental health referral form would be sent to her if a child's behavioral screening required a follow-up with mental health (pursuant to this PREA provision). She explained how she meets with each resident in the facility to assess their mental state and wellbeing, and that the residents that are deemed at risk of sexual victimization or abusiveness are provided a mental health follow-up within a day or two after they are admitted into the facility.

The auditor was advised during the initial meeting on day one that the facility had one resident currently in detention who identified as a victim of prior sexual victimization while in the community during the intake risk screening process. The auditor interviewed this resident who explained that this sexual abuse incident was reported to an intake officer during the previous detention and that she was provided mental health services. The resident informed the auditor that she was provided a follow-up with the agency's MHP one day after her initial detention and that she also met with a victim advocate and the MHP for the agency during her last detention.

The auditor requested to review the behavioral screens (risk screening, pursuant to PREA Standard §115.341) of each resident interviewed (9 out of the available 13 screening forms) in order to verify that there was only one resident whose behavioral screen indicated sexual victimization and one resident's whose screening indicated previous perpetration of sexual abuse. Upon the auditor's review of the nine (9) behavioral screenings, the auditor confirmed the agency provided the auditor with the correct information.

Furthermore, the auditor interviewed a staff member who is responsible for working intake and conducting resident risk screenings. This officer advised the auditor that the facility utilizes their behavioral screening (risk screening) form to screen residents upon their admission into the facility for risk of sexual abuse victimization and abusiveness. The intake officer described how the MHP is notified and assesses each child, regardless of the risk screening results, within one or two days of being admitted. It was explained that if the MHP is not available (not

in the building), the MHP is contacted over the phone and follows up with the child within a day or two. The intake officer also explained that the MHP has a face-to-face meeting with every resident admitted into the facility, regardless of the results of the Behavioral Screening, within a day or two of each resident's admission into the facility- with prioritizing the residents who are screened as risk of sexual victimization or abusiveness. If a resident's Behavioral Screening indicates that the child is at risk of being victimized or abusing another resident, this officer advised that she would immediately notify the Superintendent, Casework Manager, and a Detention Supervisor to await further instructions.

Additionally, it should be noted that agency Policy 16.2 on page 6 that a medical screening should be scheduled when a new juvenile is admitted, and that this screening is to be completed by the County Health authority.

115.381 (c):
Policy 16.2 on page 2 states that "any information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to medical and mental health practitioners and other staff, as necessary, for inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law.

Additionally, Policy 12.5 on page 13 outlines the agency's responsibility related to confidentiality and includes- "information concerning the identity of a victim reporting sexual abuse, and the facts of the report itself, will be limited to those who have a need to know in order to make decisions concerning the juvenile's welfare and for law enforcement and TJJD investigative purposes.

The auditor's interviews with the 12 randomly selected staff (JSOs) indicated that staff are aware of the agency's confidentiality procedures, and staff advised that they would only share sensitive information regarding an allegation of sexual abuse to supervisory staff, administrative staff involved in the investigation, mental and medical health staff as appropriate for applicable treatment, and law enforcement officials involved in the investigation.

During the onsite, the auditor verified that the resident files are kept securely locked in the main control room.

115.381 (d):
Policy 16.2 on page 2 states that medical and mental health professionals shall obtain informed consent from juveniles before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the juvenile is under the age of 18.

Per Chapter 51 of the Texas Family Code, which defines a child as ten years of age or older and under 17 years of age, a juvenile detention center may only admit a child who is under 18 years of age. Therefore, all the residents in the MRJJC are under the age of 18, as was confirmed by the auditor through reviewing the resident roster while onsite, which included each resident's age and date of birth.

Additionally, Family Code Chapter 32 of Section. 32.001 (Consent by Non-parent) states: an

adult responsible for the actual care, control, and possession of a child under the jurisdiction of a juvenile court or committed by a juvenile court to the care of an agency of the state or county
may consent to medical, dental, psychological, and surgical treatment of a child when the person having the right to consent as otherwise provided by law cannot be contacted and that person has not given actual notice to the contrary.

The auditor also interviewed the agency's Mental Health Provider (MHP), who explained that each resident's parent or guardian signs a consent for treatment form when their child is detained. Additionally, the MHP advised that she or the Detention Superintendent would contact the resident's parent or guardian to ensure the parent/guardian is notified of a sexual abuse outcry made by a resident, unless the parent/guardian is the alleged perpetrator.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.382 Access to emergency medical and mental health services

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.382

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 12.5 (Sexual Abuse & Mistreatment) / Last updated: 09/02/2016
- Garth House Working Protocols

Interviews:

- Medical and Mental Health Staff
- First Responders
- Randomly Selected Staff (JSOs)

Explanation of determination:

115.382 (a):
Policy 12.5 on page 6 describes that juvenile victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, with the nature and scope of which are determined by medical and mental health practitioners according to their professional judgement.

Additionally, the auditor reviewed the agency's working protocols agreement with the Garth House that includes the requirement of the Garth House to provide a referred victim of sexual abuse specialized trauma-focused mental health services that include:

- Crisis intervention
- Trauma-specific assessment including full trauma history
- Standardized assessment measures
- Individualized written treatment plan
- Individualized evidence-informed treatment
- Trauma-informed Caregiver group for parents or other caregivers
- Referral to other community resources to meet special needs, higher level of care, and/or as part of after-care planning
- Clinical supervision

This working agreement the MRJJC has with the Garth House also includes the requirement of the Garth House to provide a referred victim of sexual abuse a forensic nurse examiner. This specialized nurse is required to provide the following:
- Provides trauma-informed mental health assessment and treatment for eligible children and their caregivers
- Helps ensure the health and well-being of the child by providing appropriate education and reassurance for the child and caregiver

- Makes referrals as needed for other medical care

The auditor interviewed the nurse who explained that resident victims of sexual abuse receive immediate and unimpeded access to emergency medical treatment and crisis intervention services, and that in such instances, emergency services would be immediately contacted (911) and she would be notified either in-person, if in the facility, or over the phone, if away. The nature and scope of these services would be determined to the Doctor's professional judgment, per the nurse.

The agency's fulltime MHP was also interviewed and advised that that resident victims of sexual abuse would receive immediate and unimpeded access to emergency medical treatment and crisis intervention services, and that she and the agency would adhere to any follow-up services the hospital provides.

115.382 (b):
Policy 12.5 on page 6 explains that if no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, staff first responders shall take preliminary steps to protect the victim pursuant to §115.362 and shall immediately notify the appropriate medical and mental health practitioners.

It should be noted that each security staff member (JSO) working in the MRJJC has been trained on their responsibilities as a first responder, as indicated in standard explanation §115.333 of this report. Additionally, the auditor interviewed a random sample of JSO staff, 12 total, who all were able to clearly articulate their first responder duties related to a situation involving sexual abuse or sexual harassment of a resident.

Additionally, the auditor interviewed a randomly selected JSO who has been trained as a first responder and asked questions specifically related to this PREA provision. The JSO explained to the auditor that the victim's safety is the number one priority, and that he would take the necessary steps to protect the victim as required by his training and departmental policy and procedure. The necessary steps were explained by the JSO as: separating the alleged victim and abuser, preserving and protecting the scene, requesting that the alleged victim and perpetrator not take any action that could destroy physical evidence, and immediately notifying medical and mental health services.

115.382 (c):
Policy 12.5 on page 8 and 9 outlines the agency's responsibilities of ensuring a resident victim of sexual abuse is offered timely information and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate.

The agency's contracted nurse advised the auditor that residents who are victims of sexual abuse are offered timely information about access to emergency contraception and sexually transmitted infection prophylaxis.

Additionally, the agency's MHP also confirmed the requirements of this provision are provided to all residents victims, and that a resident victim of sexual abuse would be referred to a local hospital for medical assessment and applicable treatment and provided a pamphlet that

outlines information related to emergency contraception and sexually transmitted infections prophylaxis.

115.382 (d):
Policy 12.5 on page 10 explicitly states that treatment services are provided at no cost to the victim, regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

Additionally, it should be noted that both organizations the agency contracts with for victim services, the Rape and Suicide Crisis Center and the Garth House, both are non-profit agencies that provide the services to a resident of the MRJJC at no cost to the victim or victim's family.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.383 Ongoing medical and mental health care for sexual abuse victims and abusers

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.383

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 12.5 (Sexual Abuse & Mistreatment) / Last updated: 09/02/2016
- Agency Policy 16.2 (Admission Procedures) / Last updated: 06/16/2016

Interviews:

- Medical and Mental Health Staff

Explanation of determination:

115.383 (a-b):
Policy 12.5 on pages 8 outlines the agency's requirement to offer medical and mental health evaluations and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility. This Policy states that a victim of any type of sexual abuse will:

- receive a mental health assessment as soon as possible;
- receive a medical assessment as soon as possible;
- be provided emergency counseling to include independent certified rape crisis counseling, if desired by the victim.

Additionally, Policy 12.5 states that if a MHP determines that a juvenile needs mental health services, the MHP must notify the appropriate staff of their recommendations, and that upon notification of the MHP's recommendation for continued mental health services, the appropriate staff will implement the recommendation/s and document accordingly. Policy 12.5 also states that the evaluation and treatment of victims of sexual abuse shall 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.

Furthermore, the auditor reviewed the agency's working protocols agreement with the Garth House that includes the requirement of the Garth House to provide a referred victim of sexual abuse specialized trauma-focused mental health services that include:

- Crisis intervention
- Trauma-specific assessment including full trauma history
- Standardized assessment measures
- Individualized written treatment plan
- Individualized evidence-informed treatment
- Trauma-informed Caregiver group for parents or other caregivers

- Referral to other community resources to meet special needs, higher level of care, and/or as part of after-care planning
- Clinical supervision

115.383 (c):
Policy 12.5 on page 9 states that the facility shall provide victims of sexual abuse with medical and mental health services consistent with the community level of care.

The auditor interviewed one contracted nurse and the fulltime MHP who both indicated in their interviews that the requirement of this provision holds true for the MRJJC, and both practitioners also provided the same opinion that the level of care provided to residents may be better than what would be available to them in the community.

115.383 (d-e):
Policy 12.5 on page 9 explains that juvenile victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests, and if pregnancy results are positive, such victims shall receive timely and comprehensive information about timely access to all lawful pregnancy-related medical services.

The agency's contracted nurse advised the auditor that if pregnancy would result from sexual abuse while a resident was in detention, the victim would immediately (as medically appropriate) be provided information and access to all lawful pregnancy-related services.

The agency's fulltime MHP also advised the same information provided by the contracted nurse, that a victim of sexual abuse would be immediately (as medically appropriate) provided information and access to all lawful pregnancy-related services.

115.383 (f & g):
Policy 12.5 on page 9 states that juvenile victims of sexual abuse while incarcerated shall be offered test for sexually transmitted infections as medically appropriate, and that all services shall be 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.

115.383 (h):
Policy 16.2 on page 2 explains that the department (MRJJC) shall attempt to conduct a mental health evaluation of all known juvenile-on-juvenile abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by MHP.

The agency's MHP advised the auditor during her interview that she has never been made aware of any resident-on-resident sexual abuse incident, and that if a resident were to sexually assault/abuse another resident in the MRJJC, she would conduct a mental health evaluation of abusers as soon as she is made aware and offer treatment if appropriate. Furthermore, as documented earlier in this report, the agency's MHP is a licensed Sex Offender Treatment Provider, and she is able to provide specialized mental health care for a perpetrator, and victim, of sexual abuse.

The agency's contracted nurse advised the auditor that there is a section on the medical assessment that she conducts with all residents that assesses for mental health issues and

she can make referrals to the agency's MHP or psychiatric services.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.386 Sexual abuse incident reviews

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.386

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 12.5 (Sexual Abuse & Mistreatment) / Last updated: 09/02/2016

Interviews:

- Detention Superintendent (PC)
- Incident Review Team Member (PC)

Explanation of determination:

115.386 (a-e):
Agency Policy 12.5 on pages 13 and 14 outlines the agency's procedures for conducting a sexual abuse incident review within 30 days from the conclusion of every sexual abuse investigation (criminal and/or administrative), including unsubstantiated dispositions, unless the allegation has been determined to be unfounded. The review team include the Chief JPO, Casework Manager, Detention Superintendent (PC), two Detention Casework Supervisors, investigators, and any medical and mental health practitioner that are available. Policy 12.5 includes the six (6) review team requirements pursuant to PREA provision §115.386 (d), and the requirement that the department shall implement the recommendations for improvement or shall document its reason for not doing so.

The Detention Superintendent (who is also the PC) advised the auditor that the MRJJC does have a sexual abuse incident review team (that he is a member of), and that the team includes upper level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners. He also listed the designated staff members whom are a part of the sexual abuse incident review team and explained that the team would seek input from everyone and anyone involved in the incident. The PC explained how the team would consider whether the incident or allegation was motivated by race; ethnicity; gender identify; lesbian, gay, bisexual, transgender, or intersex identification status or perceived status; gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. He also described how the team would 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, and assess whether monitoring technology should be deployed or augmented to supplement supervision by staff (assessing for blind spots, as well).

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is

required.

115.387 Data collection

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.387

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 12.5 (Sexual Abuse & Mistreatment) / Last updated: 09/02/2016
- MRJJC Year-over-Year Analysis of Sexual Abuse and Sexual Harassment Data (2013-2018 & includes 2018 Contract Placement Data).
- Survey of Sexual Violence conducted by the Department of Justice from calendar year 2018

Interviews:

- PREA Coordinator

Explanation of determination:

115.387 (a-d):
Policy 12.5 on page 14 outlines the agency's procedures for collecting accurate, uniform data for every allegation of sexual abuse at the MRJJC (*MRJJC is the only facility under the direct control of the JCJPD) using a standardized instrument and set of definitions. The Policy also explains that the data is aggregated at least annually by the department. The agency's Year-over-Year Analysis of Sexual Abuse and Sexual Harassment Data sheet provides for the requirements of this standard, and the form includes 26 total sexual abuse and sexual harassment criteria that the agency has to complete every year. It should be noted that this form retains statistics from 2013 to 2018 (with zero sexual abuse or sexual harassment allegations reported to the auditor for calendar year 2019). Upon further review of the agency's Year-to-Year Analysis form, the auditor determined that incident-based data collected includes, at a minimum, the data necessary to answer all the questions from the most recent version of the Survey of Sexual Violence (SSV) conducted by the Department of Justice. Additionally, the agency also has this PREA provision documented in Policy 12.5 on page 14. The auditor also was provided the agency's SSV report that was completed for calendar year 2018 that documented the agency had zero sexual abuse or sexual harassment allegations in 2018 and included the all the required statistical information. The agency reported in this standard section in the PAQ that they maintain, review, and collect data as needed from all available incident-based documents, including reports, investigative files, and sexual abuse incident reviews; and this PREA provision is also documented in Policy 12.5 on page 14.

The auditor interviewed the PC, and he explained that the MRJJC reviews 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, and training. The PC informed the auditor that the data collected is securely retained through ensuring that the data is only accessible to staff who need the information for their job related duties and maintained in the

secure detention center (*locked in a filing cabinet in a locked room in PC's office- verified by the auditor during the onsite). He also confirmed that the form that includes the data required by this standard is posted on the agency's website and all identifiers are redacted. Additionally, the PC advised the auditor that agency leadership (including himself- Detention Superintendent and PC) continually reviews all data related to PREA and sexual abuse and sexual harassment, including data from contracted placement facilities, to ensure corrective action is taken on an ongoing basis. Furthermore, the PC explained that the Chief and the PC conduct a form annual review (pursuant to §115.387 and §115.388) of the sexual abuse and sexual harassment data collected from the MRJJC and private contracted facilities.

115.387 (e & f):
Agency Policy 12.5 on page 14 explains that the MRJJC obtains incident-based and aggregate data from every private facility in which it contracts for the confinement of its residents. Additionally, the agency's Year-over-Year Analysis of Sexual Abuse and Sexual Harassment Data form includes sexual abuse and sexual harassment incident-based and aggregate data for each of the placements they contract with. Policy 12.5 also states that the MRJJC shall provide the Department of Justice (DOJ) with data from the previous calendar year upon request, and as noted above, the agency provided the auditor with their 2018 SSV report that was submitted to the DOJ.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.388 Data review for corrective action

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.388

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 12.5 (Sexual Abuse & Mistreatment) / Last updated: 09/02/2016
- JCJPD's website page: https://co.jefferson.tx.us/juvenile/Main.htm

Interviews:

- Agency Head
- PREA Coordinator

Explanation of determination:

115.388 (a-d):
Policy 12.5 on page 14 includes procedures requiring the MRJJC to review the data that is collected and aggregated annually pursuant to §115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training included:

- identifying problem areas;
- taking corrective action on an ongoing basis; and
- preparing an annual report of its findings and corrective actions for the department as a whole.

Additionally, Policy 12.5 outlines procedures requiring the agency to include a comparison of the current year's data and corrective actions with those from prior years on the annual report, and that the annual report shall provide an assessment of the agency's progress in addressing sexual abuse. Policy 12.5 states that the Chief JPO shall approve the annual report and that the report will be made readily available to the public annually through their website. This was verified by the auditor upon review of the agency's website, which included the agency's Annual Review of Sexual Abuse/Sexual Harassment Incidents from May 14, 2019. Furthermore, Policy 12.5 on page 14 explains that the department may redact specific material from the report when publication would present a clear and specific threat to the safety and security of the facility, but the report must indicate the nature of the material redacted.

The auditor reviewed the agency's annual report completed in calendar years 2016 and 2019, and each report was found to be in full compliance with the provision requirements of this standard. It should be noted that the agency reported to the auditor that the annual report was not completed for calendar years 2017 or 2018, and due to the annual requirements of this standard, the agency was found to be in non-compliance with this standard therefore

prompting the need for corrective action.

During the pre-onsite audit phase, the Casework Manager provided to the auditor an improvement plan to address the non-compliance with this standard to ensure future annual reviews pursuant to this PREA standard will be completed going forward. This plan involves the Superintendent being responsible for updating the agency's Annual Inspection List and emailing it to all Detention Supervisors, the Casework Manager, and the Chief. The Casework Manager confirmed with the auditor that the Superintendent has already updated the annual inspection list with the following annual PREA requirements and this list was provided to the auditor:

- Staffing Plan Assessment;
- PREA MOUs; and
- Annual Review of Sexual Abuse/Sexual Harassment Incidents.

Ultimately, the auditor determined that for calendar year 2019 the agency has complied with and institutionalized the PREA annual review and report requirements pursuant to §115.388 of reviewing and documenting on a report the data collected and aggregated pursuant to §115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, response policies, and training. The Agency has institutionalized Policy 12.5 (that includes the requirements of the PREA standard) and provided the Auditor with their Annual Review of Sexual Abuse/Sexual Harassment Incidents from May 14th, 2019. It should be noted that this 2019 report fulfils the requirements of this PREA Standard provision for 2019. With the corrective action plan already fully implemented (as determined by the auditor through conversations with the Chief, Casework Manager, and Superintendent and the documentation provided of the annual list), future annual PREA reviews an reports pursuant to this standard and other annual reviews and inspections should not be missed.

The auditor interviewed the PC, and he explained that the MRJJC reviews 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, and training. The PC informed the auditor that the data collected is securely retained through ensuring that the data is only accessible to staff who need the information for their job related duties and maintained in the secure detention center (*locked in a filing cabinet in a locked room in PC's office- verified by the auditor during the onsite). He also confirmed that the form that includes the data required by this standard is posted on the agency's website and all identifiers are redacted. Additionally, the PC advised the auditor that agency leadership (including himself- Detention Superintendent and PC) continually reviews all data related to PREA and sexual abuse and sexual harassment, including data from contracted placement facilities, to ensure corrective action is taken on an ongoing basis. Furthermore, the PC explained that the Chief and the PC conduct a form annual review (pursuant to §115.387 and §115.388) of the sexual abuse and sexual harassment data collected from the MRJJC and private contracted facilities.

The Chief of the JCJPD was also interviewed by the auditor, and he explained that incident-based sexual abuse data is used to assess and improve sexual abuse prevention, detection, response policies, practices, and training. The data is therefore used, as indicated by the Chief, to identify any problems or deficiencies and corrective action is taken as a result to enhance sexual safety for the residents and staff in the MRJJC and the private facilities they

contract with. The Chief also advised that he approves annual reports written pursuant to §115.388, but that the reports were not completed for calendar years 2017 and 2018 (as indicated earlier).

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.389 Data storage, publication, and destruction

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.389

The following is a list of evidence used to determine compliance:

- Pre-Audit Questionnaire (PAQ)
- Agency Policy 12.5 (Sexual Abuse & Mistreatment) / Last updated: 09/02/2016

Interviews:

- PREA Coordinator/PC (who is also the Detention Superintendent)

Explanation of determination:

115.389 (a-d):
Policy 12.5 on page 15 states that the department must ensure that the data collected are securely retained and that all personal identifiers must be removed before making aggregated sexual abuse data publicly available. This policy also includes requirements for the MRJJC to make sexual abuse data from the MRJJC and the placement facilities with which the department contracts with readily available to the public at least annually through the department's county website. Furthermore, 12.5 explains that sexual abuse data collected must be retained for at least 10 years after the date of its initial collection unless Federal, State, and local law requires otherwise. In order to verify the agency's compliance with this standard, the auditor reviewed the agency's website, and the site includes a PREA section with links to PREA related reports, statistical data, and PREA detention information for the public. The links are easily accessible on the agency's home page, and includes the MRJJC's 201 PREA Year-over-Year Analysis. This document includes all the requirements pursuant to PREA standards §115.387, §115.388, and §115.389. Additionally, it should be noted that the documents provided do not include any personal identifiers and the sexual abuse and sexual harassment aggregated data includes information from the MRJJC and private facilities with which it contracts with. Furthermore, the data maintained on the agency's Year-over-Year form includes data from 2013 to 2018.

The auditor interviewed the PC, and he explained that the MRJJC reviews 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, and training. The PC informed the auditor that the data collected is securely retained through ensuring that the data is only accessible to staff who need the information for their job related duties and maintained in the secure detention center (*locked in a filing cabinet in a locked room in PC's office- verified by the auditor during the onsite). He also confirmed that the form that includes the data required by this standard is posted on the agency's website and all identifiers are redacted. Additionally, the PC advised the auditor that agency leadership (including himself- Detention Superintendent and PC) continually reviews all data related to PREA and sexual abuse and sexual harassment, including data from contracted placement facilities, to ensure corrective

action is taken on an ongoing basis. Furthermore, the PC explained that the Chief and the PC conduct a form annual review (pursuant to §115.387 and §115.388) of the sexual abuse and sexual harassment data collected from the MRJJC and private contracted facilities.

Conclusion:
Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with all elements of this standard. No corrective action is required.

115.401 Frequency and scope of audits

Auditor Overall Determination: Meets Standard

Auditor Discussion

115.401:
Upon the auditor's review of the agency's website, the auditor determined that the MRJJC finalized their last PREA audit on October 5th, 2016. The agency's website includes their Final PREA Audit Report that reflects the agency was in full compliance with all 41 PREA standards. Additionally, the Jefferson County Juvenile Probation Department (JCJPD) only includes one facility, the Minnie Rogers Juvenile Justice Center (MRJJC). The auditor was allowed access to all areas of the facility, provided all the necessary agency documentation, allowed to conduct private interviews with staff and residents, and there were never any roadblocks or issues to report during the entire audit process. Additionally, residents were permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel.

115.403 Audit contents and findings

Auditor Overall Determination: Meets Standard

Auditor Discussion

The auditor verified on the agency's website that their last PREA audit's final report was published, and the agency has been instructed by the auditor to publish this final report upon receipt but no longer than 90 days of the issuance by the auditor. The auditor will verify that the agency publishes this report within 90 days.

Appendix: Provision Findings

115.311 (a) Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment?	yes
Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment?	yes

115.311 (b) Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

Has the agency employed or designated an agency-wide PREA Coordinator?	yes
Is the PREA Coordinator position in the upper-level of the agency hierarchy?	yes
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

115.311 (c) Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.)	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.)	na

115.312 (a) Contracting with other entities for the confinement of residents

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

115.312 (b) Contracting with other entities for the confinement of residents

Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents OR the response to 115.312(a)-1 is "NO".)	yes

115.313 (a) Supervision and monitoring

Does the agency ensure that each facility has developed a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
Does the agency ensure that each facility has implemented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
Does the agency ensure that each facility has documented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The prevalence of substantiated and unsubstantiated incidents of sexual abuse?	yes
Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Generally accepted juvenile detention and correctional/secure residential practices?	yes
Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any judicial findings of inadequacy?	yes
Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from Federal investigative agencies?	yes
Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies?	yes

Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)?	yes
Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The composition of the resident population?	yes
Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The number and placement of supervisory staff?	yes
Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Institution programs occurring on a particular shift?	yes
Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any applicable State or local laws, regulations, or standards?	yes
Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any other relevant factors?	yes

115.313 (b) Supervision and monitoring

Does the agency comply with the staffing plan except during limited and discrete exigent circumstances?	yes
In circumstances where the staffing plan is not complied with, does the facility fully document all deviations from the plan? (N/A if no deviations from staffing plan.)	na

115.313 (c) Supervision and monitoring

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 only until October 1, 2017.)	yes
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 only until October 1, 2017.)	yes
Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A only until October 1, 2017.)	yes
Does the facility ensure only security staff are included when calculating these ratios? (N/A only until October 1, 2017.)	yes
Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph?	no

115.313 (d) Supervision and monitoring

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
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
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
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

115.313 (e) Supervision and monitoring

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
Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities)	yes
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

115.315 (a) Limits to cross-gender viewing and searches

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

115.315 (b) Limits to cross-gender viewing and searches

Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances?	yes

115.315 (c) Limits to cross-gender viewing and searches

Does the facility document and justify all cross-gender strip searches and cross-gender visual body cavity searches?	yes
Does the facility document all cross-gender pat-down searches?	yes

115.315 (d) Limits to cross-gender viewing and searches

Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks?	yes
Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit?	yes
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)	na

115.315 (e) Limits to cross-gender viewing and searches

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
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

115.315 (f) Limits to cross-gender viewing and searches

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
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

115.316 (a) Residents with disabilities and residents who are limited English proficient

Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all	yes

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?	
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
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
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
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
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
Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing?	yes
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
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
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
Does the agency ensure that written materials are provided in formats or	yes

through methods that ensure effective communication with residents with disabilities including residents who: Who are blind or have low vision?

115.316 (b) Residents with disabilities and residents who are limited English proficient

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
Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes

115.316 (c) Residents with disabilities and residents who are limited English proficient

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

115.317 (a) Hiring and promotion decisions

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
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
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 bullet immediately above?	yes
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
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
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 two bullets immediately above?	yes

115.317 (b) Hiring and promotion decisions

Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents?	yes

115.317 (c) Hiring and promotion decisions

Before hiring new employees who may have contact with residents, does the agency: Perform a criminal background records check?	yes
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
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

115.317 (d) Hiring and promotion decisions

Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents?	yes
Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents?	yes

115.317 (e) Hiring and promotion decisions

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

115.317 (f) Hiring and promotion decisions

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
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
Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct?	yes

115.317 (g) Hiring and promotion decisions

Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination?	yes

115.317 (h) Hiring and promotion decisions

Unless prohibited by law, does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.)	yes

115.318 (a) Upgrades to facilities and technologies

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.)	na

115.318 (b) Upgrades to facilities and technologies

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

115.321 (a) Evidence protocol and forensic medical examinations

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

115.321 (b) Evidence protocol and forensic medical examinations

Is this protocol developmentally appropriate for youth? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)	yes
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

115.321 (c) Evidence protocol and forensic medical examinations

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
Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible?	yes
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
Has the agency documented its efforts to provide SAFEs or SANEs?	yes

115.321 (d) Evidence protocol and forensic medical examinations

Does the agency attempt to make available to the victim a victim advocate from a rape crisis center?	yes
If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member?	yes
Has the agency documented its efforts to secure services from rape crisis centers?	yes

115.321 (e) Evidence protocol and forensic medical examinations

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
As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals?	yes

115.321 (f) Evidence protocol and forensic medical examinations

If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating entity follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency is not responsible for investigating allegations of sexual abuse.)	yes

115.321 (h) Evidence protocol and forensic medical examinations

If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.321(d) above.)	na

115.322 (a) Policies to ensure referrals of allegations for investigations

Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse?	yes
Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment?	yes

115.322 (b) Policies to ensure referrals of allegations for investigations

Does the agency have a policy 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
Has the agency published such policy on its website or, if it does not have one, made the policy available through other means?	yes
Does the agency document all such referrals?	yes

115.322 (c) Policies to ensure referrals of allegations for investigations

If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for criminal investigations. See 115.321(a))	yes

115.331 (a) Employee training

Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment?	yes
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
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
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
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
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
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
Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents?	yes
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
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
Does the agency train all employees who may have contact with residents on: Relevant laws regarding the applicable age of consent?	yes

115.331 (b) Employee training

Is such training tailored to the unique needs and attributes of residents of juvenile facilities?	yes
Is such training tailored to the gender of the residents at the employee's facility?	yes
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

115.331 (c) Employee training

Have all current employees who may have contact with residents received such training?	yes
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
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

115.331 (d) Employee training

Does the agency document, through employee signature or electronic verification, that employees understand the training they have received?	yes

115.332 (a) Volunteer and contractor training

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

115.332 (b) Volunteer and contractor training

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

115.332 (c) Volunteer and contractor training

Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received?	yes

115.333 (a) Resident education

During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment?	yes
During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment?	yes
Is this information presented in an age-appropriate fashion?	yes

115.333 (b) Resident education

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
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
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

115.333 (c) Resident education

Have all residents received such education?	yes
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

115.333 (d) Resident education

Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient?	yes
Does the agency provide resident education in formats accessible to all residents including those who: Are deaf?	yes
Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired?	yes
Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled?	yes
Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills?	yes

115.333 (e) Resident education

Does the agency maintain documentation of resident participation in these education sessions?	yes

115.333 (f) Resident education

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

115.334 (a) Specialized training: Investigations

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

115.334 (b) Specialized training: Investigations

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
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
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
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

115.334 (c) Specialized training: Investigations

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

115.335 (a) Specialized training: Medical and mental health care

Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment?	yes
Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse?	yes
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?	yes
Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment?	yes

115.335 (b) Specialized training: Medical and mental health care

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.)	no

115.335 (c) Specialized training: Medical and mental health care

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?	yes

115.335 (d) Specialized training: Medical and mental health care

Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331?	yes
Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.332?	yes

115.341 (a) Obtaining information from residents

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
Does the agency also obtain this information periodically throughout a resident's confinement?	yes

115.341 (b) Obtaining information from residents

Are all PREA screening assessments conducted using an objective screening instrument?	yes

115.341 (c) Obtaining information from residents

During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Prior sexual victimization or abusiveness?	yes
During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: 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
During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Current charges and offense history?	yes
During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Age?	yes
During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Level of emotional and cognitive development?	yes
During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical size and stature?	yes
During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Mental illness or mental disabilities?	yes
During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Intellectual or developmental disabilities?	yes
During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical disabilities?	yes
During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: The resident's own perception of vulnerability?	yes
During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents?	yes

115.341 (d) Obtaining information from residents

Is this information ascertained: Through conversations with the resident during the intake process and medical mental health screenings?	yes
Is this information ascertained: During classification assessments?	yes
Is this information ascertained: By reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files?	yes

115.341 (e) Obtaining information from residents

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

115.342 (a) Placement of residents

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
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
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
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
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

115.342 (b) Placement of residents

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?	yes
During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise?	yes
During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services?	yes
Do residents in isolation receive daily visits from a medical or mental health care clinician?	yes
Do residents also have access to other programs and work opportunities to the extent possible?	yes

115.342 (c) Placement of residents

Does the agency always refrain from placing: Lesbian, gay, and bisexual residents in particular housing, bed, or other assignments solely on the basis of such identification or status?	yes
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
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
Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator or likelihood of being sexually abusive?	yes

115.342 (d) Placement of residents

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
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

115.342 (e) Placement of residents

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

115.342 (f) Placement of residents

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

115.342 (g) Placement of residents

Are transgender and intersex residents given the opportunity to shower separately from other residents?	yes

115.342 (h) Placement of residents

If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A for h and i if facility doesn't use isolation?)	yes
If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A for h and i if facility doesn't use isolation?)	yes

115.342 (i) Placement of residents

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?	yes

115.351 (a) Resident reporting

Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment?	yes
Does the agency provide multiple internal ways for residents to privately report: 2. Retaliation by other residents or staff for reporting sexual abuse and sexual harassment?	yes
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

115.351 (b) Resident reporting

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
Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials?	yes
Does that private entity or office allow the resident to remain anonymous upon request?	yes
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?	no

115.351 (c) Resident reporting

Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties?	yes
Do staff members promptly document any verbal reports of sexual abuse and sexual harassment?	yes

115.351 (d) Resident reporting

Does the facility provide residents with access to tools necessary to make a written report?	yes

115.351 (e) Resident reporting

Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents?	yes

115.352 (a) Exhaustion of administrative remedies

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.	no

115.352 (b) Exhaustion of administrative remedies

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
Does the agency always refrain from requiring an 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

115.352 (c) Exhaustion of administrative remedies

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
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

115.352 (d) Exhaustion of administrative remedies

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
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
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

115.352 (e) Exhaustion of administrative remedies

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
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
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
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
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

115.352 (f) Exhaustion of administrative remedies

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
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
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
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
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
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
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

115.352 (g) Exhaustion of administrative remedies

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

115.353 (a) Resident access to outside confidential support services and legal representation

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 accessible mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations?	yes
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?	yes
Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible?	yes

115.353 (b) Resident access to outside confidential support services and legal representation

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

115.353 (c) Resident access to outside confidential support services and legal representation

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
Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements?	yes

115.353 (d) Resident access to outside confidential support services and legal representation

Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation?	yes
Does the facility provide residents with reasonable access to parents or legal guardians?	yes

115.354 (a) Third-party reporting

Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment?	yes
Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident?	yes

115.361 (a) Staff and agency reporting duties

Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency?	yes
Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment?	yes
Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation?	yes

115.361 (b) Staff and agency reporting duties

Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws?	yes

115.361 (c) Staff and agency reporting duties

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

115.361 (d) Staff and agency reporting duties

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
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

115.361 (e) Staff and agency reporting duties

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
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
If the 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? (N/A if the alleged victim is not under the guardianship of the child welfare system.)	yes
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

115.361 (f) Staff and agency reporting duties

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

115.362 (a) Agency protection duties

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

115.363 (a) Reporting to other confinement facilities

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
Does the head of the facility that received the allegation also notify the appropriate investigative agency?	yes

115.363 (b) Reporting to other confinement facilities

Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation?	yes

115.363 (c) Reporting to other confinement facilities

Does the agency document that it has provided such notification?	yes

115.363 (d) Reporting to other confinement facilities

Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards?	yes

115.364 (a) Staff first responder duties

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
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
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
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

115.364 (b) Staff first responder duties

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

115.365 (a) Coordinated response

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

115.366 (a) Preservation of ability to protect residents from contact with abusers

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

115.367 (a) Agency protection against retaliation

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
Has the agency designated which staff members or departments are charged with monitoring retaliation?	yes

115.367 (b) Agency protection against retaliation

Does the agency employ multiple protection measures for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations, 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?	yes

115.367 (c) Agency protection against retaliation

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
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
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
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
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
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
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
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
Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need?	yes

115.367 (d) Agency protection against retaliation

In the case of residents, does such monitoring also include periodic status checks?	yes

115.367 (e) Agency protection against retaliation

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

115.368 (a) Post-allegation protective custody

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

115.371 (a) Criminal and administrative agency investigations

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 does not conduct any form of administrative or criminal investigations of sexual abuse or harassment. See 115.321(a).)	yes
Does the agency conduct such investigations for all allegations, including third party and anonymous reports? (N/A if the agency does not conduct any form of administrative or criminal investigations of sexual abuse or harassment. See 115.321(a).)	yes

115.371 (b) Criminal and administrative agency investigations

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

115.371 (c) Criminal and administrative agency investigations

Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data?	yes
Do investigators interview alleged victims, suspected perpetrators, and witnesses?	yes
Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator?	yes

115.371 (d) Criminal and administrative agency investigations

Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation?	yes

115.371 (e) Criminal and administrative agency investigations

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

115.371 (f) Criminal and administrative agency investigations

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
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

115.371 (g) Criminal and administrative agency investigations

Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse?	yes
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

115.371 (h) Criminal and administrative agency investigations

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

115.371 (i) Criminal and administrative agency investigations

Are all substantiated allegations of conduct that appears to be criminal referred for prosecution?	yes

115.371 (j) Criminal and administrative agency investigations

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

115.371 (k) Criminal and administrative agency investigations

Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the facility or agency does not provide a basis for terminating an investigation?	yes

115.371 (m) Criminal and administrative agency investigations

When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.321(a).)	yes

115.372 (a) Evidentiary standard for administrative investigations

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

115.373 (a) Reporting to residents

Following an investigation into a resident's allegation of sexual abuse suffered in the facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded?	yes

115.373 (b) Reporting to residents

If the agency did not conduct the investigation into a resident's allegation of sexual abuse in an agency facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.)	yes

115.373 (c) Reporting to residents

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
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
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
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

115.373 (d) Reporting to residents

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
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

115.373 (e) Reporting to residents

Does the agency document all such notifications or attempted notifications?	yes

115.376 (a) Disciplinary sanctions for staff

Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies?	yes

115.376 (b) Disciplinary sanctions for staff

Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse?	yes

115.376 (c) Disciplinary sanctions for staff

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

115.376 (d) Disciplinary sanctions for staff

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
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

115.377 (a) Corrective action for contractors and volunteers

Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents?	yes
Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)?	yes
Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies?	yes

115.377 (b) Corrective action for contractors and volunteers

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

115.378 (a) Interventions and disciplinary sanctions for residents

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

115.378 (b) Interventions and disciplinary sanctions for residents

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
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
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
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
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

115.378 (c) Interventions and disciplinary sanctions for residents

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

115.378 (d) Interventions and disciplinary sanctions for residents

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
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

115.378 (e) Interventions and disciplinary sanctions for residents

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

115.378 (f) Interventions and disciplinary sanctions for residents

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

115.378 (g) Interventions and disciplinary sanctions for 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

115.381 (a) Medical and mental health screenings; history of sexual abuse

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

115.381 (b) Medical and mental health screenings; history of sexual abuse

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

115.381 (c) Medical and mental health screenings; history of sexual abuse

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

115.381 (d) Medical and mental health screenings; history of sexual abuse

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

115.382 (a) Access to emergency medical and mental health services

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

115.382 (b) Access to emergency medical and mental health services

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
Do staff first responders immediately notify the appropriate medical and mental health practitioners?	yes

115.382 (c) Access to emergency medical and mental health services

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

115.382 (d) Access to emergency medical and mental health services

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

115.383 (a) Ongoing medical and mental health care for sexual abuse victims and abusers

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

115.383 (b) Ongoing medical and mental health care for sexual abuse victims and abusers

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

115.383 (c) Ongoing medical and mental health care for sexual abuse victims and abusers

Does the facility provide such victims with medical and mental health services consistent with the community level of care?	yes

115.383 (d) Ongoing medical and mental health care for sexual abuse victims and abusers

Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.)	yes

115.383 (e) Ongoing medical and mental health care for sexual abuse victims and abusers

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.)	yes

115.383 (f) Ongoing medical and mental health care for sexual abuse victims and abusers

Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate?	yes

115.383 (g) Ongoing medical and mental health care for sexual abuse victims and abusers

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

115.383 (h) Ongoing medical and mental health care for sexual abuse victims and abusers

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

115.386 (a) Sexual abuse incident reviews

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

115.386 (b) Sexual abuse incident reviews

Does such review ordinarily occur within 30 days of the conclusion of the investigation?	yes

115.386 (c) Sexual abuse incident reviews

Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners?	yes

115.386 (d) Sexual abuse incident reviews

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
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
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
Does the review team: Assess the adequacy of staffing levels in that area during different shifts?	yes
Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff?	yes
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

115.386 (e) Sexual abuse incident reviews

Does the facility implement the recommendations for improvement, or document its reasons for not doing so?	yes

115.387 (a) Data collection

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

115.387 (b) Data collection

Does the agency aggregate the incident-based sexual abuse data at least annually?	yes

115.387 (c) Data collection

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

115.387 (d) Data collection

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

115.387 (e) Data collection

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

115.387 (f) Data collection

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

115.388 (a) Data review for corrective action

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
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
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

115.388 (b) Data review for corrective action

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

115.388 (c) Data review for corrective action

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

115.388 (d) Data review for corrective action

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

115.389 (a) Data storage, publication, and destruction

Does the agency ensure that data collected pursuant to § 115.387 are securely retained?	yes

115.389 (b) Data storage, publication, and destruction

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

115.389 (c) Data storage, publication, and destruction

Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available?	yes

115.389 (d) Data storage, publication, and destruction

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

115.401 (a) Frequency and scope of audits

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

115.401 (b) Frequency and scope of audits

Is this the first year of the current audit cycle? (Note: a “no” response does not impact overall compliance with this standard.)	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
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.)	na

115.401 (h) Frequency and scope of audits

Did the auditor have access to, and the ability to observe, all areas of the audited facility?	yes

115.401 (i) Frequency and scope of audits

Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)?	yes

115.401 (m) Frequency and scope of audits

Was the auditor permitted to conduct private interviews with inmates, residents, and detainees?	yes

115.401 (n) Frequency and scope of audits

Were inmates, residents, and detainees permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel?	yes

115.403 (f) Audit contents and findings

The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A only 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