PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of Report: August 22, 2017

Auditor Information				
Auditor Name: Glen E. McKenzie, Jr. M.S.H.P.				
Address: 202 Walton Way, Suite 192-141, Cedar Park, TX 78613				
Email: GlenEMcKenzieJr.LLC@austin.rr.com for PREA Audit Purposes Only				
Telephone number:	512-576-1800			
Date of facility visit:	August 15-16, 2017			
Facility Information:				
Facility name: Taylor County Juvenile Justice Center				
Facility Physical Address: 889 South 25th Street, Abilene, Texas 79602				
Facility Mailing Address (If different from above)				
Facility Telephone number:	325-691-7462			
The facility is:	☐ Military	X County	☐ Federal	
	☐ Private for profit	☐ Municipal	☐ State	
	☐ Private not for profit			
Facility Type:	X Detention	☐ Correction	☐ Other – Residential Group Care Home	
Name of Facility Chief Executive Officer: Allison A Stafford				
Number of staff assigned to the facility in the past 12 months: 29 Juvenile Correctional Officers				
Designed Facility Capacity: 22				
Facility Security Levels/Resident custody levels: Secure Pre-Adjudication Detention				
Age Range of Population: 10-17				
Name of PREA Coordinator				
Jessica Lopez		Title: PREA Coordinator/Quality Assurance Officer		
Email address: lopezj@taylorcountytexas.org		Telephone number: 325-691-7462		
Agency Information				
Name of agency: Taylor County Juvenile Probation Department				
Governing authority or parent agency: *(if applicable)*	Taylor County Juvenile Board			
Physical address: 889 South 25th Street, Abilene, Texas 79602				
Mailing address: *(if different from above)*				

Telephone number:	325-691-7462		
Agency Chief Executive Officer			
Name: Allison A. Stafford		**Title:**	Chief Juvenile Probation Officer
Email address:	stafforda@taylorcountytexas.org	**Telephone number:**	325-691-7462
Agency-Wide PREA Coordinator			
		Title:	
Email address:		**Telephone number:**	

AUDIT FINDINGS

NARRATIVE

Overview

The Prison Rape Elimination Act (PREA) on-site audit of the Taylor County Juvenile Justice Center in Abilene, Texas was conducted on August 15-16, 2017 by Glen E. McKenzie, Jr., M.S.H.P. from Cedar Park, Texas, and a U.S. Department of Justice Certified PREA Auditor for Adult and Juvenile facilities. On the first day of the audit, the Auditor conducted an entrance conference, toured all areas of the facility and began interviews of random and specialized staff and randomly selected residents the specialized resident. On the second day of the audit, the Auditor spent the balance of the on-site audit interviewing additional specialized and random staff and completed all interviews. The Auditor also reviewed selected staff, contractor, volunteer and resident files and additional documents. Following completion of the on-site visit on August 16, 2017, the Auditor conducted an exit conference with the Facility Administration and staff to discuss preliminary findings and the subsequent audit processes and timeframes. The Auditor's comments were positively received during the audit by all the facility staff and administrators. Residents and staff were readily accessible at all times to the Auditor for the conduct of formal interviews. The Interim Deputy Chief of Secure Facilities provided unimpeded access to all parts of the facility to the Auditor at all times and provided ample office space during the on-site audit. The Executive Director (Chief Juvenile Probation Officer) and facility staff demonstrated that PREA compliance is a priority as demonstrated by the high quality of preparation of the Pre-Audit Questionnaire (PAQ) and organization of information provided to the Auditor.

Pre-Audit Phase

On June 28, 2017, the Auditor sent the facility the PREA Audit Notices to be posted in the facility. On June 28, 2017, the Auditor received electronic photographic evidence to demonstrate that proper posting of these notices had been placed in the resident housing units, the main entrance of the facility, other areas of the facility and in the administration area of the facility. The audit notice had also been posted on the facility's website. http://www.taylorcountytexas.org/524/PREA-Audit-Notice. As of the audit report date, the Auditor had not received any confidential correspondence via postal service mail or during the on-site audit.

The Taylor County Juvenile Justice Center staffs were requested to complete the Pre-Audit Questionnaire (PAQ) which was provided to the Auditor on a thumb drive along with supporting documents on July 15, 2017 preceding the on-site review portion of the audit. Pre-audit preparation by the Auditor included a thorough review of all documentation and materials submitted by the facility along with the data included in the completed Pre-Audit Questionnaire. The documentation reviewed included facility policies, procedures, forms, education materials, training curriculum, organizational charts, posters, brochures and other PREA related materials that were provided to demonstrate compliance with the PREA standards. This review prompted very few questions. On the afternoon of August 14, 2017, the Auditor met with the PREA Coordinator and the Quality Assurance Officer/Court Liaison who provided answers/clarification of those few Auditor questions prior

to the on-site portion of the audit. On the morning of August 15, 2017, the PREA Coordinator provided the Auditor with a complete listing of key administrative personnel, specialized staff (e.g., contract administrator [Interim Deputy Chief of Secure Facilities], human resources staff, medical staff, random staff, screening staff, intake staff, investigative staff, volunteers, contractors, etc.) and a listing of all residents which included the name of a specialized resident (who identified herself as being bisexual). The Auditor selected the staff and determined that all residents would be interviewed during the on-site audit. The Auditor also selected specific files (i.e., new hires, employees promoted, investigations, training records, etc.) to be reviewed during the on-site audit.

On-Site Audit Phase

On the morning of August 15, 2017 the Auditor arrived at the facility at 8:15 a.m. and was shown to the PREA Coordinator's office in the administration wing of the building which would function as working base during the audit. The Auditor began by conducting an entrance conference with facility administration at 8:30 a.m. After introductions and welcoming remarks were made by the Agency Executive Director (Chief Juvenile Probation Officer) and Interim Deputy Chief of Secure Facilities, the Auditor discussed the audit schedule and an overview of the audit processes. Following the entrance conference, the auditor was escorted into the detention facility for purposes of conducting an on-sight tour of the facility. During the tour the auditor observed camera placements to identify potential blind spots, observed staff placement and resident supervision, observed zero tolerance posters, PREA audit notice postings, reviewed the video monitoring system in the control room area, confidential resident files, unit logs, grievance forms, locked grievance boxes and hotline phone numbers posted in each living unit. The Auditor was provided unimpeded access to all parts of the facility, all secure rooms and storage areas in the facility. During the tour the auditor informally interviewed staffs and residents regarding sexual safety and facility policies and procedures. Following the facility tour, the auditor was led back to the PREA Coordinator's office to discuss observations with PREA Coordinator, Interim Deputy Chief Secure of Facilities and the Quality Assurance/Court Liaison staff. Any additional questions were answered by executive and upper-level management staff. During the remaining duration of the on-site audit, the Auditor conducted private staff and contractor interviews in a private office and interviewed residents in a private visitation room within the detention center.

Site Review. On the first day of the audit after the entrance conference, the Auditor toured the physical plant escorted by the PREA Coordinator/Quality Assurance Officer, the Quality Assurance/Court Liaison staff and the Interim Deputy Chief of Secure Facilities. The Auditor spoke informally with staff and residents during the tour which covered all housing and common areas of the facility, day areas, programming areas, and shower and toilet areas. The Auditor noted video camera placements throughout the facility and reviewed the video monitoring system in the secure control room area. The auditor was informed of the location of two (2) video cameras strategically added since the last PREA audit; with the total number of cameras being 32 cameras inside the facility and 8 on the outside perimeter. The auditor observed Notices of the PREA Audit posted throughout the facility as required.

During the on-site review of the physical plant, the Auditor observed, among other things, the facility configuration, staff supervision of residents, dorm layout including individual wet sleeping rooms, shower/toilet areas, placement of PREA posters and PREA informational resources, security monitoring, resident movement procedures, resident programming and resident interaction with staff. The tour concluded after approximately one (1) hour.

Resident populations on the first day of the audit were as followed:

- Boys "A" Hall (9 rooms); (7 residents)
- Boys "B" Hall (9 rooms); (3 residents)
- Girls "C" Hall (4 rooms); (0 residents)
- During the on-site audit, two (2) youth were released and not available for interview

Interviews. Formal private interviews were conducted with facility, staff, residents and contractors. No volunteers were available for interview during the on-site audit. Twenty-four total facility staff members were interviewed during the on-site review which included administrative staff, random staff and specialized staff. Two (2) medical contractors were interviewed. The auditor interviewed ten (10) random staff representing all shifts in the programs and thirteen specialized staff performing eleven (11) functions. The facility shifts are:

- Shift 1: 7 : 00 A.M. -3:00 P.M.;
- Shift 2: 3 :00 P.M. -11:00 P.M.;
- Shift 3: 1 1 :00P.M. - 7:00 A.M.

During the on-site audit, the auditor interviewed the following staffs: Agency Executive Director (Chief Juvenile Probation Officer), Interim Deputy Chief of Secure Facilities, PREA Coordinator, intermediate/higher-level facility staff who conduct unannounced visits to the facility during the all shifts, medical and mental health staff, human resources staff (Interim Deputy Chief of Secure Facilities), staff members who monitor for retaliation, staff who performs screening for risk of victimization and abusiveness, incident review team staff, the staffs responsible for monitoring for retaliation, first responders, intake staff, security staff, the medical contractors and ten (10) random correctional officers. There were no volunteers interviewed as none were at the facility or available during the audit. All were interviewed using the DOJ protocols that question their PREA training and overall knowledge of the facility's zero tolerance policy, reporting mechanisms available to residents and staff, the response protocols when a resident alleges abuse, first responder duties, data collection processes and other pertinent PREA requirements.

The resident population ranged from 22 residents in July 2016 to 34 residents in June 2017. In the previous 12 months, a total of 280 residents had been admitted to the facility. The age range of resident population is 10 years to 17 years of age. No resident had requested to speak with the auditor nor had the auditor received any written correspondence from any resident or staff. In the prior 12 months, there had been two (2) allegations of sexual abuse and zero (0) allegations the facility received that a resident was abused while confined at another facility. One (1) sexual abuse allegation was referred to Taylor County Sheriff's Office and one (1) allegation was referred to TJJD. During the investigation by the Sheriff's Office and while the resident was awaiting a SANE examination, the resident recanted the allegation. Although the resident recanted the allegation, the investigation was completed and determined to be unfounded. The allegation referred to the TJJD was determined to be a grievance and determined to be unfounded. The two (2) residents were subsequently notified of the outcome of the investigation.

On the first day of the on-site review, there were 10 residents (i.e., 8 males and 2 females) housed in the facility in two (2) of the three (3) housing units. The third housing unit was unoccupied during the audit. During the on-site audit and prior to resident interviews, two (2) residents were released. The Auditor interviewed all remaining eight (8) residents from the two (2) occupied housing units representing approximately 100% of the resident population. There were no residents at the facility who had reported a sexual abuse incident, no residents who were disabled and limited English proficient, transgender, intersex, gay, lesbian, no residents in isolation and no residents who disclosed prior victimization during risk screening. The Auditor also interviewed the one (1) female resident who identified as bisexual using both the random and specialized interview protocols. Both male and female residents were interviewed six (6) males and two (2) females. Residents were interviewed using the Department of Justice (DOJ) protocols that question their knowledge of a variety of PREA protections generally and specifically their knowledge of reporting mechanisms available to residents to report sexual abuse or harassment. There were no residents at the facility who had disclosed prior sexual victimization during risk screening and there were no residents placed in isolation for the purposes of separating residents who identified as transgender, intersex, gay, lesbian or bisexual**.**

The auditor reviewed the Memorandum of Understanding (MOU) between the facility and Hendricks Medical Center to provide SANE and SAFE services and the agreement between the Taylor County Juvenile Board and NOAH Project of Abilene to provide a 24-hour hotline for reporting sexual abuse and sexual harassment as well as counseling services for victims and victim support. The auditor spoke with the Hendricks Medical Center SANE Director to confirm the MOU and SANE/SAFE services to be provided as required and at no cost to the

residents. Directors from both the agencies stated that their agencies had agreed to provide relevant services; although none had been provided. All allegations of sexual abuse or sexual harassment are to be reported to the Taylor County Sheriff's Office which had agreed through a Memorandum of Understanding to conduct criminal investigations. The auditor communicated with the Taylor County Sheriff's Office representative who confirmed that criminal investigative services would be provided to the detention center as needed. The agency Executive Director (Chief Juvenile Probation Officer) and the Sheriff's Office representative confirmed the accuracy with statements contained in the PAQ that in the last year, two (2) allegations of sexual abuse had been made. One (1) administrative investigation was conducted by the facility, Taylor County Sheriff's Department and by TJJD determined that the sexual abuse allegation was a resident grievance and determined to be unfounded. The second investigation conducted by the Taylor County Sheriff's Office was investigated and determined to be unfounded. Administrative investigations are to be conducted by a trained staff at the agency facility. The auditor also contacted the toll free hot-line (TJJD) and spoke with an operator who explained their office accepted sexual abuse allegations at any time.

The Taylor County Juvenile Detention Center's mission is stated as "Changing Lives for a Brighter Future".

File Review. The Auditor requested the facility to provide a listing of personnel and resident files for possible review. From those listings, the Auditor selected a random sample of files to review and notified the facility. All files were provided to the Auditor in the main conference room where the Auditor was based. Prior to the on-site audit, the PREA Coordinator provided the Auditor with a listing of staff by hire date which cited dates for criminal records and child abuse registry checks and documentation of check with prior institutional employers. In order to verify compliance, the auditor selected at random four (4) employee personnel files which were reviewed applicable to hiring and training requirements. Two (2) files for volunteers and two (2) files for contractors were reviewed. Prior to the on-site audit, the PREA Coordinator also provided the Auditor with a listing of residents by admission date, screening date and orientation/comprehensive education dates. Case files for two (2) youth in the facility randomly selected were reviewed on-site to evaluate screening and intake procedures, resident education and other general programmatic areas.

Exit Conference. The Auditor conducted an exit conference with the facility officials on the afternoon of Wednesday, August 16, 2017. Facility administration and staff were very open and receptive to discussion of any area where PREA compliance possibly could continue to be improved.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Taylor County Juvenile Justice (Detention) Center is located in Abilene, Texas and is part of Taylor and Jones counties in West Texas, United States. As of the census of 2010, there were 117,063 people, 47,783 households, and 32,524 families residing in the county. The population density was 1,096.2 people per square mile (53/km²). There were 52,056 housing units at an average density of 57 per square mile (22/km²). The racial makeup of the county 75.5% White, 9.6% Black or African American, 0.7% Native American, 1.7% Asian, 0.01% Pacific Islander, 8.35% from other races, and 3.3% from two or more races and 24.5% of the populations were Hispanic or Latino of any race.

There were 42,348 households out of which 34.70% had children under the age of 18 living with them, 53.80% were married couples living together, 11.50% had a female householder with no husband present, and 31.20% were non-families. 25.70% of all households were made up of individuals and 9.70% had someone living alone who was 65 years of age or older. The average household size was 2.54 and the average family size was 3.07.

In the county, the population was spread out with 23.4% under the age of 18, 13.80% from 18 to 24, 27.80% from 25 to 44, 19.30% from 45 to 64, and 12.50% who were 65 years of age or older. The median age was 32 years. For every 100 females there were 94.10 males. For every 100 females age 18 and over, there were 91.10 males.

The median income for a household in the county was $34,035, and the median income for a family was $40,859. Males had a median income of $28,964 versus $21,021 for females. The per capita income for the county was $17,176. About 10.40% of families and 14.50% of the population were below the poverty line, including 17.60% of those under age 18 and 9.20% of those ages 65 or over.

The Taylor County Juvenile Justice Center operates a secure detention center. The facility is located at the Juvenile Department's headquarters at 889 South 25th Street, Abilene Texas, 79602, adjacent to the Taylor County Sheriff's Department. The detention center is a secure environment for youth charged with an offense and pending a court hearing. The facility is designed to provide a safe living environment and a range of services for the juvenile to include: medical, educational, psychological and recreational services. The facility is equipped and staffed to meet the residents' basic needs, including academic instruction through a service contract with the Abilene Independent School District.

The fundamental goal of the program is to provide a safe and secure environment for residents and staff, while the staff gathers valuable information regarding the child's family, school, social, medical, and psychological histories, to aid the Probation Services Division in the disposition of the case.

The Taylor County Juvenile Justice Center is a co-ed facility certified by the Texas Juvenile Justice Department (TJJD) to house up to 22 youth ages 10 to 17, who have been arrested by a law enforcement facility and charged with a criminal offense, and juveniles alleged to have violated their conditions of probation and are waiting Juvenile Court processing. The average length of stay is approximately 16 days. The facility physical plant includes 22 single-occupancy wet rooms.

It should be noted that facility staff were very familiar with the residents; knew their individual names, their background, treatment needs, characteristics and their involvement with families. Staff was observed speaking politely and in a professional manner with residents. There were many staffs that had numerous years of service at the facility. Staff spoke highly of the facility managers, of other employees and the numerous programs offered to residents. All residents stated they felt very safe at the facility and could speak with any staff about any issues and/or concerns.

The Taylor County Juvenile Justice Center has 40 video cameras operational, in use inside the facility as well as on the exterior of the facility. Video cameras are placed in corridors, housing units, program areas, visitation areas and exterior recreational areas. There are no cameras in individual resident rooms or in the shower or toilet areas. The classroom is equipped with video cameras covering the hallways and two cameras in the classroom. All cameras are continuously monitored by staff in the secure control room.

The facility is well maintained, in good repair and exceptionally clean. Housing units are well equipped and provide residents with a comfortable environment. Resident halls and rooms are painted soft colors to enhance the housing units and reduce the institutional feel. In walking through all the housing units in the facility as well as the school areas, the Auditor noted that the facility is quiet and order is well maintained in all areas. Staff appears to have good relationships with the residents and residents appear to follow the direction of staff which contributes to a calm environment conducive to rehabilitation.

The facility is certified by the local Juvenile Board as required by the Texas Family Code. The programs are also regulated by the State of Texas via the Texas Juvenile Justice Department (TJJD). Texas Administrative Code Title 37, Chapter 343 governs secure pre- and post-adjudication facilities and imposes significant rules on the operations and programming. Of note are the current TJJD mandatory staffing ratios as detailed below:

- Single Occupancy Housing Units: 1/12:1/24 (Program Hours, Non-Program Hours)
- Building-Wide Ratio: 1/8:1/18 (Program, Non-Program)

The detention facility offers a variety of programming and services for residents. The facility has health services provided by a Physician's Assistant and through a contract physician that comes to the facility according to

schedule and as needed. A Physician's Assistant manages the psychotropic medication for residents at the facility and trained Juvenile Supervision Officers administer medications. The facility has a strong community volunteer program consisting of 22 volunteers and contractors who serve the facility residents.

SUMMARY OF AUDIT FINDINGS

During the past 12 months, the Taylor County Juvenile Justice Center reported one (2) allegations of sexual abuse or sexual harassment occurred in the facility. One (1) administrative investigation was conducted into that allegation and was determined by the Texas Juvenile Justice Department to be a facility grievance rather than an allegation of sexual abuse or sexual harassment and one (1) criminal investigation was conducted by the Taylor County Sheriff's Department which was determined to be unfounded.

The facility has a strong zero tolerance policy in place and comprehensive PREA policies covering all the requirements of the PREA standards. The facility has an overarching Central Administration set of policies approved by the Executive Director for PREA compliance issues.

Overall, interviews with residents reflected that they are aware of and understand the PREA protections and the facility's zero tolerance policy. Residents stated they received written materials at intake (e.g., Resident Handbooks, etc.) that provided detailed information about PREA protections, the multiple ways to report sexual abuse or harassment and ways to protect them from abuse. Subsequent to intake, residents are provided more comprehensive education on PREA that includes personal instruction in addition to being required to watch a comprehensive PREA educational video. Posters related to reporting sexual abuse and sexual harassment are placed in dayrooms of the facility and in housing units. Residents indicated they understood the various ways to report abuse internally and externally.

Residents stated to the Auditor how they would properly report any incident of sexual abuse and knew to whom they should report if they experienced or had knowledge of another resident who had experienced sexual abuse. Residents expressed to the Auditor that they trust staff and could report sexual abuse to almost any staff in the facility. The Auditor's observation of staffs' interactions with residents was positive and appropriate. Residents consistently indicated to the Auditor that they felt safe in the facility.

All facility staff interviewed stated they had received detailed training in PREA policies and procedures and could accurately describe the meaning of the facility's zero tolerance policy. Staffs were knowledgeable of their roles and responsibilities in the prevention, detection, reporting and response to sexual abuse, sexual harassment or retaliation. Staffs were able to describe the variety of reporting mechanisms for residents, staff, contractors and volunteers to report sexual abuse, sexual harassment or retaliation. Staffs demonstrated they were well trained on the PREA first responder's protocol for any PREA related allegation and they could describe clearly the appropriate steps they would follow if they were a first responder to such incidents. The PREA Coordinator/Quality Assurance staff and other staff stated that on-going periodic training was conducted to reinforce the importance of maintaining knowledge of all issues related to preventing, detecting, reporting and responding to sexual abuse, sexual harassment and retaliation. Staff knew residents by name and treated the residents with a sense of care and concern. Many employees at the facility have a long tenure and expressed their dedication to their roles at the facility and their work with residents.

In summary, following the review of all pertinent information, observations from the on-site review, interviews with residents and staffs, the Auditor determined that the facility leadership and staff made PREA compliance a high priority. It was evident that a significant amount of time and resources had been devoted to policy and procedure development, staff training and residents' orientation/education on all aspects of PREA. The Auditor reviewed the PREA training material/curriculum and noted that the PREA Coordinator and facility staffs have done well in the utilization of the training resources from the PREA Resource Center website as well as other county, state and national information and training resources. The high level of pre-audit preparations, organization of audit files and other documentation reviewed submitted in the PAQ to the Auditor facilitated the conduct of the PREA audit.

The facility has a strong PREA policy (written around the PREA standards) which reinforced the facility's commitment to ensuring the sexual safety of residents and staff in the facility. The positive culture of sexual safety in this facility is evident in the overall operations of this facility and the level of PREA compliance as observed by this Auditor. The Auditor noted the overwhelmingly positive attitude from facility administration and the PREA compliance team toward any Auditor input on any suggestions for possible improvement.

PREA Standards Compliance Overview – Final Audit Report

The Taylor County Juvenile Justice Center has achieved full compliance with all PREA standards as of the date of this final report. The summary of compliance based upon this final report is found below.

PREA Standards Compliance Overview – Final Audit Report

Number of standards exceeded: 0

Number of standards met: 41

- **§115.311; 115.312; §115.313; §115.315; §115.316; §115.317§115.318; and**
- **§115.321; §115.322; and**
- **§115.331; 115.332; §115.333; §115.334; §115.335; and**
- **§115.341; §115.342 and**
- **§115.351; §115.352; §115.353; §115.354; and**
- **§115.361; §115.362; §115.363; §115.364; §115.365; 115.366; §115,367; §115.368; and**
- **§115.371; §115.372; §115.373; §115.376; §115.377; §115.378; and**
- **§115.381; §115.382; §115,383; §115.386; §115,387; §115.388; §115.389.**

Number of standards not met: 0

Number of standards not applicable: 0

Total Standards: 41

Standard 115.311 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

Evidence Reviewed (documents, interviews, site review):

1. Facility PREA Policy Chapter 6 Section III 115.311 Prevention Planning Policy
2. Facility PREA Policy Chapter 6 Section I 115.311 Federal PREA Guidelines Introduction
3. Zero Tolerance Policy and How To Report Posters placed in the facility
4. Facility Organization Chart identifying PREA Coordinator
5. Interview with PREA Coordinator

Findings (By Subsection):

Subsection (a): Facility policy 115.311 III [A-B] - Zero Tolerance of Sexual Abuse and Sexual Harassment; PREA Coordinator is a comprehensive policy on sexual abuse and sexual harassment contained in PREA Prevention Planning. The policy clearly mandates zero tolerance toward all forms of sexual abuse and sexual harassment. The policy is detailed and well written. The policy contains definitions that are compliant and consistent with the PREA definitions in the PREA Definitions section. The policy further outlines the facility's approach to preventing, detecting, and responding to sexual abuse and sexual harassment.

Subsection (b): Jessica Lopez is the designated facility wide PREA Coordinator and her official title is PREA Coordinator/Quality Assurance Officer. As identified in the agency organizational chart, the PREA Coordinator reports directly through the Deputy Chief of Fiscal Services. The PREA Coordinator has direct access to the agency Executive Director (Chief Juvenile Probation Officer). The PREA Coordinator reports that she has sufficient time and authority to develop, implement and oversee facility efforts to comply with PREA. Ms. Lopez has done an exemplary job of overseeing the PREA compliance efforts of the facility.

Subsection (c): The Taylor County Juvenile Justice Center is a single facility.

Corrective Action: None.

Standard 115.312 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

Evidence Reviewed (documents, interviews, site review):

1. Facility policy Chapter 6 Section III 115.312 [D] Contracting With Other Entities for the Confinement of Residents.
2. Facility contracts with service agencies requiring compliance with the Prison Rape Elimination Act of 2003
3. Fiscal Year 2016 and Fiscal Year 2017 Residential Services Contracts
4. Interviews with the following:
    a. PREA Coordinator
    b. Facility's Contract Administrator

Findings (By Subsection):

Subsection (a): Facility policy Section D (1) provides all residential service contracts must include provisions that require the service provider to comply with PREA. The facility currently has one (1) residential service provider contract with a county juvenile probation department which has not been utilized. The Auditor reviewed that contract required by agency policy to contain the PREA language that requires compliance of the service provider with the PREA standards. The contract includes the entity to adopt and comply with the PREA standards.

Subsection (b): Facility policy Section D (3) requires that residential contracts will provide that the facility will monitor the progress of their residential service providers at regular intervals. Interviews with the Executive Director (Chief Juvenile Probation Officer) and the Deputy Chief of Fiscal Services confirmed the monitoring requirement will be performed by staff trained in PREA standards if the residential contract is needed in the future.

Corrective Action: None.

Standard 115.313 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

☐ Not Applicable

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.

Evidence Reviewed (documents, interviews, site review):

1. Facility policy Chapter 6 Section III 115.313 [E] Supervision and Monitoring
2. Vulnerability Assessment (2/7/2017 and 7/11/2017)
3. Staffing Plan (2/8/2017)
4. Annual Staffing Plan Review (7/11/2017)
5. Unannounced Rounds Log
7. Interviews with random staff and random residents
8. Interviews with the following:
    a. Interim Deputy Chief of Secure Facilities PREA Coordinator
    b. Intermediate or Higher-Level Facility Staff

Findings (By Subsection):

Subsection (a): Facility policy Section III, E (3-1; a-k) requires the facility to develop staffing plans for its facility. The Auditor reviewed the agency policy which documented the requirement that the staffing plan which addresses the 11 required elements of this standard. Interviews with the Interim Deputy Chief of Secure Facilities and the PREA Coordinator demonstrated that all elements required have been met.

Subsection (b): Facility policy Section III E (2) dictates that deviations are only allowed during limited and

discrete exigent circumstances. There had been no deviations from the staffing plan documented on the PAQ. The agency has developed a form to document such deviations should that be necessary. An interview with the Interim Deputy Chief of Secure Facilities confirmed that there had been no deviations to the staffing plan.

Subsection (c): Facility policy Section III E (2) requires the required staffing ratios will be met no later than October 1, 2017. The tour however reflected the staff ratios reflected the 1:8 during resident waking hours and 1:16 during resident sleeping hours and was further evidenced by the Unannounced Rounds Logs on all shifts. An interview with the Interim Deputy Chief of Secure Facilities confirmed the facility meets the PREA staffing requirements. Only security staff counts toward these ratios. Deviations are only allowed during limited and discrete exigent circumstances. The facility exceeds the requirement of this subsection related due to an advanced compliance implementation date.

Subsection (d): Facility policy Section III, E (4 a-d) requires the annual review of the staffing plan. The facility staffing plan was officially reviewed on 7/11/2017. The PREA Coordinator presented the staffing plan annual review which included prevailing staffing patterns, use of monitoring technology and adequate resources to meet the staffing plan. She indicated the facility plans to perform subsequent annual reviews as to document the PREA mandated staffing ratio.

Subsection (e): Facility policy Section III, E (5) requires intermediate and higher level supervisory personnel in each program to conduct and document unannounced rounds at least once per shift each month. Documentation of the unannounced visits by intermediate and higher-level supervisors is documented on the "PREA Unannounced Round Form". A random review PREA Unannounced Round Forms documented unannounced visits on all shifts monthly as required. Interviews with intermediate or higher-level staff confirmed the random reviews were conducted.

Corrective Action: None

Standard 115.315 Limits to cross-gender viewing and searches

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

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.

Evidence Reviewed (documents, interviews, site review):

1. Facility policy Chapter 6 Section III 115.315 [H] Limits to cross-gender viewing and searches
2. Facility form Cross-Gender Strip Search and/or Cavity Search
3. Facility training curriculum – "Guidance in Cross-Gender and Transgender Pat Searches" (PREA Resource Center training document)
4. Facility training acknowledgement form documenting training of detention center staff on Cross-Gender and Transgender Pat Searches

Interviews with the following:

a. random residents
b. random staff

Findings (By Subsection):

Subsection (a): Facility policy Section III H (3) prohibits cross-gender strip or pat searches, only in exigent circumstances or when performed by LVN/Physician/Physician's Assistant; allowing residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing, requiring opposite gender announcements, justification and documentation requirements for all cross-gender strip searches, cross-gender visual body cavity searches, and cross gender pat-down searches.

Subsection (b): Facility policy Section III H (3) prohibits cross-gender strip or pat searches, except in exigent circumstances. There have been no cross-gender pat searches as documented in the PAQ and verified through interviews with residents and staff.

Subsection (c): Facility policy Section III H (3) requires all authorized searches to be justified and documented.

Subsection (d): Facility policy Section III H (2) requires that all residents are able to shower, perform bodily functions, and change clothing without nonmedical staff viewing their genitals, buttocks, breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks (including viewing via video camera and recordings). Unless there is an exigent circumstance staff of the opposite gender entering a unit will announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing. Staff will document on the unit log if an exigent circumstance occurred. The Auditor noted that during the tour of the facility physical plant, the PREA Coordinator and other staff made opposite gender announcements appropriately upon entering each of the housing units. Compliance was further confirmed through random staff and random resident interviews.

Subsection (e): Facility policy Section III H (4) requires clearly that staff 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 conversation with the resident, by reviewing medical records, or, if necessary by learning that information as a part of a broader medical exam conducted in private by a medical practitioner. This policy prohibits the search of a transgender or intersex resident for the sole purpose of determining the resident's genital status. Interviews with random staff corroborated that no such searches had been conducted at the facility. There were no identified transgender or intersex residents in the facility during the on-site audit.

Subsection (f): Facility policy Section III H (6) requires that all security staff shall be trained how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in professional and respectful manner, and in the least intrusive manner possible, consistent with security needs. The auditor confirmed that the facility had trained all staff on how to conduct pat-down searches of transgender and intersex residents in a professional and respectful manner and in the least intrusive manner possible. Training documentation was submitted to evidence this and interviews with staff indicate they could articulate proper search procedures for pat-down searches which are the only searches they are allowed to conduct.

Corrective Action: None

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

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

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.

Evidence Reviewed (documents, interviews, site review):

1. Facility policy Chapter 6 Section III 115.316 [I] Residents with Disabilities and Residents Who are Limited English Proficient
2. Resident Pamphlet – "End The Silence"
3. Training Curriculum/training logs related to disabled residents and residents with limited English proficiency
4. Language Line Services, Inc. Memorandum of Understanding, December 20, 2016
5. Interview – Interim Deputy Chief of Secure Facilities
6. Interviews – disabled/limited English proficient residents and random staff

Findings (By Subsection):

Subsection (a): The facility Section III I (1) has established procedures to provide disabled residents equal opportunity to participate in and benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The facility utilizes Language Line Services, Inc. and Communication by Hand, LLC for their translation needs. PREA posters are posted throughout the facility in Spanish as well as English. Resident handbooks containing information of this service are available in both English and Spanish.

Subsection (b): The facility Section III I (2) has established policies and procedures to provide residents with limited English proficiency equal opportunity to participate in and benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The facility has multiple staff members who speak Spanish and can assist with translation when necessary. External translation services are available through contracted services when needed.

Subsection (c): The facility policy Section III I (3) prohibits relying on resident interpreters, resident readers, or other types of resident assistant except in limited circumstances as required by this subsection. Interviews with staff corroborate this policy is the practice in the facility. There were no residents with disabilities or who were of limited English proficiency at the facility during the on-site audit.

Corrective Action: None.

Standard 115.317 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

Evidence Reviewed (documents, interviews, site review):

1. Facility policy Chapter 6 Section III 115.317 [J] Hiring and promotion decisions

2. Completed Pre-Audit Questionnaire (PAQ)
3. Criminal History, Child Abuse Registry, and Prior Institutional Checks Spreadsheet (Employees and Contractors)
4. Reference Check Form PREA
5. Personnel files for current employees, new employees and employees receiving promotions
6. Volunteer/Contractor files
7. Interviews with the following:
    a. Agency Executive Director,
    b. Interim Deputy Chief of Secure Facilities
    c. Human Resources staff (Agency Executive Director) and
    d. PREA Coordinator

Findings (By Subsection):

Subsection (a): Taylor County Juvenile Justice Center has not hired, promoted anyone or enlisted contractor service providers who may have contact with residents who have engaged in any of the PREA standards prohibited criteria related to sexual abuse or sexual harassment. The facility policy Section III J (2) regarding hiring and promotions is compliant with this standard. The facility utilizes the State of Texas Department of Public Safety fingerprint system (FAST) to perform new employee, contractor, volunteer, intern background checks as well as for anyone who may have contact with residents. The PREA Coordinator compiled a Criminal History, Child Abuse Registry, and Prior Institutional Checks Spreadsheet of employees and contractors presented to the Auditor which demonstrated compliance with this standard subsection. The Auditor reviewed a sample of three (3) employee and two (2) contractor files and determined the facility is compliant with this standard subsection.

Subsection (b): The facility policy Section III J (3) considers 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 hiring practice requires prospective employees to answer and/or disclose PREA related conduct about all the PREA conduct detailed in this standard.

Subsection (c): The facility policy Section III J (4) requires that a criminal background check and child abuse registry check be conducted for all new employees prior to hiring. The facility utilizes the State of Texas Department of Public Safety fingerprint system (FAST) to accomplish that requirement. The Auditor reviewed an informational spreadsheet which tracks the checks and reviewed three (3) personnel files to corroborate that these checks had been completed as required by policy. The facility requires prospective employees to disclose any prior institutional employers and all places the applicant has resided for the past 10 years. Interviews with Human Resources staff corroborate this practice.

Subsection (d): The facility policy Section III J (5) requires that a criminal background check and child abuse registry check be conducted for all contractors prior to their utilization. The Auditor reviewed seven (7) Applicant Worksheets which tracks the background checks corroborated that these checks had been completed as required by policy. The PAQ submitted by the facility reports that in the past 12 months, 6 persons were hired who may have contact with residents who had criminal background checks performed. Additionally, 1 contract for services in the past 12 months had a criminal background check completed. Interviews with Human Resources staff corroborate this practice. The facility has a variety of contractors that provide services to the residents. Many of these contractors have professional licenses and criminal history checks are conducted by the licensing entity.

Subsection (e): Facility policy Section III J (10) requires criminal background checks to be completed every 2 years for current employees and contractors. This practice exceeds this section of the standard. The Auditor reviewed three (3) random personnel files of current staff and confirmed that the checks had been completed.

Subsection (f): Facility policy Section III J (7) requires the facility to ask all applicants and employees who

may have contact with residents about the PREA related misconduct in this section in written applications or interviews for hiring or promotions and as part of employees' evaluation processes. Policy also requires the facility to impose upon employees a continuing affirmative duty to disclose any such misconduct and to report such conduct immediately (within 24 hours).

Subsection (g): Facility policy Section III J (8) states that material omissions regarding PREA-related conduct, or the provision of materially false information is grounds for termination.

Subsection (h): Facility policy Section III J (9) requires the Executive Director or designee to 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. Interviews with Human Resources staff confirmed this practice.

Corrective Action: None.

Standard 115.318 Upgrades to facilities and technologies

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)
- ☐ Not Applicable

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.

Evidence Reviewed (documents, interviews, site review):

1. Pre-Audit Questionnaire (PAQ)
2. Facility policy Chapter 6 Section III 115.318 [K] Upgrades to Facilities and Technologies
3. Interviews with the following:
    a. Chief Juvenile Probation Officer
    b. Interim Deputy Chief of Secure Facilities

Findings (By Subsection):

Subsection (a): The facility has not acquired a new facility or made a substantial expansion or modification to the existing facility since the last PREA audit.

Subsection (b): Facility policy Section III K (2) governs the installation or updating video/electronic monitoring technology and requires the agency to consider how such technology may enhance its ability to protect residents from sexual abuse. The agency policy further requires that such consideration shall be documented through planning meeting minutes, statements of work, design specification and contracting documents.

Corrective Action: None.

Standard 115.321 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy Chapter 6 Section IV 115.321 [A] Evidence Protocol and forensic medical examinations
3. Written memorandum from Taylor County Sheriff's Office
4. Written agreement with Betty Hardwick Center of Abilene
5. Memorandum of Agreement between the Hendricks Medical Center and the Taylor County Juvenile Services Department.
6. Interviews with the following:
    a. Random Staff
    b. Resident who Reported a Sexual Abuse
    c. Electronic Communication with Taylor County Sheriff's Office Representative
    d. Telephone interview with SANE Director, Hendricks Medical Center
    e. Telephone interview with Chief Executive Officer, Betty Hardwick Center of Abilene
    f. Telephone interview with Program Manager, NOAH Project of Abilene

Findings (By Subsection):

Subsection (a): Facility policy Section V A (2) governs evidence protocol and forensic medical examinations. The Taylor County facility is responsible for the conduct of administrative investigations into allegations of sexual abuse. Criminal investigations are conducted by the Taylor County Sheriff's Office. The facility follows a uniform evidence protocol (first responder protocol) that maximizes the potential for obtaining usable physical evidence for administrative investigations. Facility staff has been trained in a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence. Interviews with random staff and the PREA Coordinator confirmed they utilize the protocol that maximizes the potential for obtaining usable physical evidence. Staff has been provided first responder cards that contain the first responder protocol; these cards can be carried in the staff member's pocket or duty belt to help refresh memory if and when an acute incident occurs in the facility. Staff interviews demonstrated knowledge of the first responder's evidence protocol in the facility.

Subsection (b): The facility's evidence protocol is based on the U.S. Department of justice's Office on Violence Against Women publication protocol.

Subsection (c): A written agreement completed on 9/29/2016 with the Hendricks Medical Center and the Taylor County Juvenile Justice Center provides for forensic medical examinations offered to residents without financial cost to the residents. A telephone interview with SANE Director, Hendricks Medical Center stated that the written agreement will provide forensic medical examinations without financial cost to the residents. The SANE Director explained that these services are available 24 hours per day and seven (7) days per week. Victim advocates are available through the Betty Hardwick Center and Noah Project of Abilene which provide rape crisis hotlines and counseling services for victims and victim support. There are qualified staff members at the facilities who can

provide crisis intervention and accompany/support the resident through the forensic medical examination processes/interviews, emotional support, crisis intervention, information and referrals, if requested by the resident. A telephone Interview with the SANE Director, Hendricks Medical Center confirmed that there had been no forensic medical examinations conducted with residents at the facility. The one (1) resident who reported a sexual abuse allegation recanted that allegation prior to the initiation SANE examination at the Hendricks Medical Center; consequently no SANE examination was performed. The investigation revealed that the resident stated she intended to manipulate the facility by her allegation into transferring her to a different facility.

Subsection (d) and (e): The facility has an agreement in place with Hendricks Medical Center and Noah Project of Abilene (Rape Crisis Center) to provide victim advocacy services to residents that are victims of sexual abuse. Interviews with the PREA Coordinator and Hendricks Medical Center and the Program Director, Noah Project of Abilene confirmed the MOU with the facility. There had been no residents who reported sexual abuse.

Subsection (f): The facility has a written agreement with the Taylor County Sheriff's Office as of 9/21/2016 which documents that they shall follow the requirements of this standard subsections (a) through (e). Through electronic communication with the Sheriff's Office detective, he indicated that they use a protocol entitled "Physical Evidence Handbook" developed by the Texas Department of Public Safety which is standards based on a nationally recognized protocol based on the Department of Justice Office on Violence against Women protocol developed after 2011.

Corrective Action: None.

Standard 115.322 Policies to ensure referrals of allegations for investigations

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

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.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Facility policy Chapter 6 Section IV 115.322 Policies to ensure referrals of allegations for investigations
3. Taylor County Juvenile Detention Center website link **http://www.taylorcountytexas.org/525/Reporting-Abuse**
4. Facility Incident Reports of verbal allegation of sexual abuse and sexual harassment
5. Facility administrative investigation of allegation
6. Allegation referral to TJJD for administrative investigation
7. Completed TJJD and facility administrative investigation report
8. Facility administrative investigation report and Taylor County Sheriff Department investigation of allegation
9. Interviews with Acting Director of Secure Facilities, PREA Manager, facility investigator staffs and Taylor County Sheriff's Office Investigator
10. Interviews with the following:
    a. Chief Juvenile Probation Officer
    b. Facility investigative staff

Findings (By Subsection):

Subsection (a): Facility policy Section IV [B 4(b)] requires that administrative investigations are completed for all allegations of sexual abuse and sexual harassment. The PAQ documents that the facility reports two (2) allegations in the past year. The first allegation was referred to Taylor County Sheriff's Office and notification of such had been sent to TJJD. During the first investigation by the Sheriff's Office and while the resident was awaiting a SANE examination, the resident recanted the allegation. Although the resident recanted the allegation, the investigation was completed by the Sheriff's Office and determined to be unfounded. The resident was subsequently notified of the outcome of the investigation. Interviews with agency staff confirmed that the allegation and subsequent investigation completed the investigation. The Auditor reviewed the investigation report and noted the investigation was closed as unfounded. The second allegation administratively investigated and submitted to the TJJD resulted in a finding that the referral was not an issue of sexual abuse or sexual harassment rather, it was determined to be a resident grievance. The Auditor reviewed the second allegation and noted it had been closed as unfounded. The Auditor concurred with the findings of both investigation outcomes. In the prior 12 months, there had been zero (0) allegations received by the facility that a resident was abused while confined at another facility.

Subsections (b-e): Facility policy Section IV [B 4(c, d, and g)] ensures that an administrative and/or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. Criminal cases are referred to the Taylor County Sheriff's Office and/or to the Texas Juvenile Justice Department (TJJD) that has the legal authority and responsibility to investigate all incidents occurring in the facility. The facility publishes this policy which describes responsibilities for the agency and the investigating entities on its website as reviewed by the Auditor. Interviews with facility investigative staff indicate this is the practice of the facility.

Corrective Action: None.

Standard 115.331 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Facility policy Chapter 6 Section V [A (1-5)]115.331 Employee Training
3. NIC PREA Training Curriculum: training provided by TJJD
4. Staff Training Statement of Fact (2/8/2017)
5. Taylor County Juvenile Services Staff Training Acknowledgement Form
6. PREA Training Curriculum and Materials
7. Secure Facilities Supervisor First Responder Responsibilities – Staff Note Card
8. Employee Training Records/Training Acknowledgement Form
9. Interviews with the following:
    a. Random Staff

Findings (By Subsection):

Subsection (a): Facility policy Section V [A 1(a-1)] requires all employees who may have contact with residents shall receive, during orientation, training on the 11 elements required by this subsection. The Auditor reviewed the training materials used to verify all topics were addressed. The facility has a complete training for employees on PREA policies, procedures and facility practices. The TCJJC training department has utilized a comprehensive curriculum used with facility PREA trainings. The Auditor confirmed that the required trainings had been conducted and documented thorough interviews and a review of four (4) training records documentation.

Subsection (b): Taylor County facility is a single co-ed facility and employees are not transferred from another facility. All employees are trained to work with both male and female residents. Training is tailored to the gender of the residents and to the unique needs and attributes of residents of juvenile facilities.

Subsection (c): The facility requires initial training and frequent on-going refresher training required by this subsection. The facility reports in the PAQ that 64 of 66 staffs have been trained in PREA related issues. The remaining two (2) staffs had completed the required training after the submission of the PAQ and prior to the on-site audit. A PREA training spreadsheet has been created which tracks all employees of training that is received annually. The Auditor confirmed that the required trainings had been conducted and documented through a review of the staff training reports of 66 staff and a random sample of four (4) staff training records.

Subsection (d): Following training, all employees are required to sign a statement that they understood the training provided. Documentation of such training and evidence of understanding are maintained in the employee's files. The Auditor confirmed that the required trainings had been conducted and documented through a review of the staff training reports of 66 staff and a random sample of four (4) staff training records.

Corrective Action: None.

Standard 115.332 Volunteer and contractor training

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

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.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Facility policy Chapter 6 Section [V- B] 115.332 Intern, Volunteer and Contractor Training
3. Staff Acknowledgement Form
4. Volunteer and Contractors training "PREA Overview, PREA Law, How it affects Your Job & Audit Process"
5. PREA Training Curriculum and Materials
6. Volunteer/Intern/Contractor Training Records

Findings (By Subsection):

Subsection (a): Facility policy V [B- 1] requires all contractors and volunteers that have contact with

residents are trained on their responsibilities under the facility's PREA policies and procedures regarding sexual abuse and sexual harassment prevention, detection and response. In the PAQ, the facility reports that all volunteers and contractors have been trained on PREA. A spreadsheet documenting that the required training had been provided was provided to the Auditor as evidence of training confirmation. The Auditor confirmed that the receipt of the training through contractor interviews and through a review of two (2) contractors training records documentation. There were no volunteers at the facility during the audit.

Subsection (b): Facility policy V [B- 1] provides that the level and type of training provided to volunteers and contractors is based on the services they provide and the level of contact they have with residents. All volunteers and contractors who have contact with residents had been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and how to report such incidents. The Auditor confirmed that the receipt of the training through contractor interviews and through a review of two (2) contractor training records and three (3) volunteer training records.

Subsection (c): Facility policy V [B-2] requires the facility to maintain documentation confirming that volunteers/contractors understand the training they have received. The PREA Coordinator provided training documentation with signatures of all volunteers and contractors acknowledging that they understand the training they received. The Auditor randomly selected two (2) contractor/volunteer training records and confirmed that the facility is in compliance with this standard.

Corrective Action: None.

Standard 115.333 Resident education

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

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.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Facility policy Chapter 6 Section [V. C] 115.333 Resident Education
3. PREA Unit Orientation Form with resident signature
4. Resident Admission/Release/Intake Orientation/Comprehensive Education Documentation
5. Resident PREA Education Logs
6. Resident Education Materials
   a. Resident Orientation Handbook
   b. PREA Youth Education Video – New Mexico Association of Counties
   c. PREA posters and signage
   d. PREA bookmarkers on how to report sexual abuse or sexual harassment
7. Resident files
8. Observation of signage and educational materials on display in facility housing units and programming areas during tour of physical plant
9. Interviews with the following:
   e. Intake Staff

f. Random Residents

Findings (By Subsection):

Subsection (a): Facility policy V [C (1] requires that residents receive information at the time of intake about the zero-tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment. The facility utilizes a variety of resident acknowledgement forms to document and evidence the provision of this training to residents. The PAQ documents that in the past 12 months, 280 residents were provided PREA education at intake. The PREA Coordinator presented a spreadsheet which noted date of residents' admission and date of receipt of the required information demonstrating compliance. The Auditor reviewed a sample of nine (9) resident intake records and confirmed the residents had received information about the zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents of suspicions of such behaviors.

Subsection (b): Facility policy V [C 2] requires that within 10 days of intake, the facility shall provide comprehensive age-appropriate PREA education to residents. The facility utilizes the New Mexico Association of Counties PREA Youth Education Video Facilitator's Guide. Residents view the video in either English or Spanish. The video is provided once a week on Sunday and all new residents get to review the videos and receive information led by an instructor. Three (3) resident files were reviewed randomly by the Auditor to verify the comprehensive education was occurring in a timely fashion. It was documented that all residents had received PREA resident education between one (1) and six (6) days of admission to the facility. Auditor interviews with random residents and intake staff confirmed this practice. The facility exceeds this subsection requirement.

Subsection (c): Facility policy V [C 2] requires all residents to receive the PREA training. Residents are not transferred between programs in the facility as verified by interview with intake staff.

Subsection (d): Facility policy V [C 4] requires that resident PREA education is available in assessable formats for all residents including those who are limited English proficient, deaf, visually impaired, or otherwise disabled as required by this subsection. The facility has interpreting services available, staff that are bilingual and materials in English and Spanish throughout the facility. If additional accommodation is needed, the appropriate community resource will provide for that service.

Subsection (e): Facility policy requires the facility to maintain documentation of resident participation in PREA training. Residents must sign an acknowledgement form stating they have received the training and understand it. The auditor reviewed the tracking spreadsheet as verification of resident participation in such training. The Auditor reviewed three (3) random resident files to corroborate this documentation was present.

Subsection (f): Facility policy V [C 6] requires key PREA information is continuously and readily available to residents through posters, signage, resident handbooks or other written formats. During the tour, the Auditor observed PREA posters throughout the facility in both English and Spanish. All housing units have signage with key phone numbers and addresses of entities to whom the resident can report or contact for services.

Corrective Action: None.

Standard 115.334 Specialized training: Investigations

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

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.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Facility policy Chapter 6 Section V Specialized Training: Investigations
3. National Institute of Corrections (NIC) Web-based Training
4. Investigating Sexual Abuse in a Confinement Setting – PREA Online Training Center https://nic.learn.com/learncenter.asp?id=178416
5. Interviews with the following:
    a. Investigative Staff
6. Training documentation for Investigators

Findings (By Subsection):

Subsection (a): Facility policy [D 1] requires that in addition to the general training provided to all employees, all investigators must also receive specialized training in conducting sexual abuse investigations in confinement settings. The facility has one (1) individual that has completed the PREA Resource Center training on Investigating Sexual Abuse in a Confinement Setting. The Auditor was provided with evidence of training completion of the investigator who completed the training. An interview with the facility investigator corroborates this training was completed.

Subsection (b): Facility policy [D (a-d)] requires that the specialized training include the topics detailed in this subsection. The PREA Resource Center training on Investigating Sexual Abuse in a Confinement Setting training curriculum was reviewed and is compliant with this requirement. The Auditor was provided with evidence of training completion of the investigator who completed the training. An interview with the facility investigator corroborates this training was completed.

Subsection (c): Facility policy [D (a-d)] requires the facility to maintain documentation that investigators have completed the required specialized training. The Auditor was provided documentation to substantiate compliance of specialized training for the investigator.

Corrective Action: None.

Standard 115.335 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy Chapter 6 Section V 115.335 [E (1-4)] Specialized Training: Medical and Mental

Health Care
3. A Guide for the Prevention and Reporting of Sexual Abuse with Residents
4. Video Training for Medical and Mental Health Staff – PREA Resource Center
5. Training Report documentation for Medical and Mental Health Staff
6. Interviews with the following:
    a. Medical Staff

Findings (By Subsection):

Subsection (a): Facility policy [E 2 (a-d)] requires the facility to train all full and part-time medical and mental health care practitioners who work regularly in the facility on PREA on how to detect and assess signs of sexual abuse and sexual harassment, how to preserve physical evidence of sexual abuse, hot to respond effectively and professionally and how and to whom to report allegations or suspicions of sexual abuse and sexual harassment. The facility reports that there are 2 (two) medical health practitioners at the facility and 2 (two) have received this training. Interviews with medical practitioners confirmed receipt of the required training. The detention center does not employ mental health staff but contracts for mental health services.

Subsection (b): Facility prohibits medical staff employed by the facility from conducting forensic medical exams. This subsection is therefore not applicable.

Subsection (c): Facility policy [E 3] requires the facility to maintain documentation that medical and mental health staffs have received the specialized training required by this standard. The Auditor was provided with the documentation of this mandatory training completion for 2 (two) of the 2 (two) medical health practitioners.

Subsection (d): Facility policy [E 4] requires that medical and mental health care practitioners at the facility also receive the training mandated for employees under PREA standard 115.331 including annual training updates. The detention center does not employ mental health staff but contracts for mental health services. Training documentation was provided for medical practitioners to demonstrate compliance with this subsection.

Standard 115.341 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy Chapter 6 Section VI 115.341 Obtaining Information from Residents
3. Objective Screening Instrument (Screening for Risk of Sexual Victimization and Abusiveness)
4. Spreadsheet documenting all resident screening
5. Interviews with the following:
    a. Random Residents
    b. Staff Responsible for Risk Screening
    c. PREA Coordinator

Findings (By Subsection):

Subsection (a): Facility policy [A 1] requires that a resident have a vulnerability assessment conducted upon intake and no less than 72 hours of the resident's arrival at the facility and periodically throughout a resident's confinement. The facility reports in the PAQ that during the past 12 months, 81 youth whose length of stay was for 72 hours or more were screened for risk of sexual victimization or sexual aggression. The Auditor reviewed eight (8) resident files to determine if the vulnerability assessment was occurring within 72 hours and all files reviewed were compliant. Generally, the screening occurs on the same day of admission. Interviews with intake staff and residents confirmed this practice. The facility exceeds the requirements of this subsection.

Subsection (b): Facility policy [A 1] requires the facility to use an Objective Screening Instrument (Screening for Risk of Sexual Victimization and Abusiveness).

Subsection (c): Facility policy [A 1 (a-j)] requires the facility assessment process to attempt to ascertain information about 11 specific types of information enumerated by this standard. The objective screening instrument used by the facility complies with this section. Interviews with intake staff indicate they are complying with this standard.

Subsection (d): Facility policy [A 2] requires intake staff to ascertain the information required by this standard through conversations with the resident during intake and medical and mental health screenings, during classification assessments and by review of relevant records of the youth. Interviews with intake staff indicate they are complying with this standard.

Subsection (e): Facility policy requires [A 3] the facility to ensure that sensitive information gained during the assessment process is kept confidential and only disclosed to staff with the need to know. All information gained in the assessment/screening process is kept confidential and only staff with a need to know can access this data. The facility utilizes the Juvenile Case Management System (JCMS) for their automated record system. JCMS has role-based security protocols that help facility administration ensure that information is only accessed by those with a need to know and who have been given appropriate authorization and access. Interviews with intake staff and the PREA Coordinator confirmed appropriate controls on the dissemination of sensitive information.

Standard 115.342 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy Chapter 6 Section VI 115.342 Placement of Residents in Housing, Bed, Program, Education, and Work Assignments
3. Taylor County Juvenile Detention Center – Screening for Risk of Sexual Victimization and Abusiveness Form
4. Interviews with the following:

a. Interim Deputy Chief of Secure Facilities
b. Staff Responsible for Risk Screening
c. Medical Staff

5. Resident Files

Findings (By Subsection):

Subsection (a): Facility policy [B 1] requires staff to make housing, bed, program, education, and work assignments for residents based on the information obtained in the screening process under Standard 115.341. Interviews with intake staff corroborate this policy is the practice of the facility.

Subsection (b): The facility has not and does not utilize isolation of residents at risk of sexual victimization. Interviews with a variety of staff corroborate that isolation is not used for residents at risk of sexual victimization.

Subsection (c): Facility policy [B 3] prohibits placing lesbian, gay, bisexual, transgender, or intersex residents in particular housing assignments solely on the basis of such identification or status. Policy also states that a staff is prohibited from considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusing. The interview with the PREA Coordinator confirmed that residents are not placed in particular housing units, beds or other assignments solely on the basis of such identification or status as an indicator of likelihood of being sexually abusive. There were no lesbian, gay or intersex residents in the facility during the audit. One (1) resident at the facility during the audit identified as bisexual who preferred to be placed in the female unit. Previously one (1) resident admitted to the facility on 3/2/2017 had identified as lesbian during intake screening on 3/2/2017. During the intake screening and based upon the resident's verbal report, she declared being a female, did not feel at risk of being abused, and felt okay about being in groups of people she did not know well and that there was no need for additional safety precautions and/or special housing requirements. The resident was determined to be at heightened risk of being sexually victimized or sexually abusive and she was placed on **"**A" Hall, room #1 (due to co-defendant being on C-Hall). The resident was released from the facility on 3/16/2017. The PREA Coordinator stated in an interview that the resident was not placed in a particular housing, bed or other assignments and the resident's identification status was not considered as an indicator of likelihood of being sexually abusive.

Subsection (d): Facility policy [B 4] states that a transgender or intersex resident's own view with respect to his/her own safety shall be given serious consideration. Staff making housing and programming assignments for transgender or intersex residents in the facility will be on a case-by-case basis and will require final approval from the Interim Deputy Chief of Secure Facilities. During the on-site audit, there were no identified transgender or intersex residents at the facility.

Subsection (e): Facility policy [B 5] requires the facility to reassess the placement and programming assignments for each transgender or intersex resident at least twice a year. An interview with intake staff confirmed this agency requirement; although the facility has had no transgender or intersex residents placed there.

Subsection (f): Facility policy [B 6] requires staff to give serious consideration to a transgender or intersex resident's own views with respect to his or her safety. Interviews with screening staff indicate this would be the practice when the facility has a transgender or intersex resident.

Subsection (g): Facility policy [B 7] provides that transgender and intersex residents shall have the opportunity to shower separately from other residents. Interviews with screening staff confirm this to be the practice as necessary. Showers in all single room living units in the facility are private with doors to ensure privacy.

Subsection (h): Facility policy [B 8 (a-b)] requires documentation of any residents placed in isolation including the basis for the isolation and the reason why no alternative means of separation could be achieved. The facility reports that in the past 12 months, there have been no residents at risk for sexual victimization placed in

isolation.

Subsection (i): Facility policy [B 9] requires that if a resident is at risk of sexual victimization and held in isolation, the facility will afford each such resident a review every 30 days by the facility administrator and supervisor to determine whether there is a continuing need for separation from the general population. The facility reports that in the last 12 months there have been no residents at risk for sexual victimization placed in isolation.

Corrective Action: None.

Standard 115.351 Resident reporting

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

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.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy Chapter 6 Section VII 115.351 [A (1-5)] Resident Reporting
3. Facility posting of multiple internal and external reporting telephone numbers of sexual abuse or sexual harassment – Zero Tolerance Policy posters (English and Spanish)
4. "End The Silence" Posters (English and Spanish)
5. Resident Orientation Handbook (English and Spanish)
6. Facility PREA Video
7. PREA Book Markers
8. Postings on all living units and program areas
9. Staff PREA Training Curriculum
10. observation of facility programs
11. Interviews with the following:
    a. random staff
    b. random residents

Findings (By Subsection):

Subsection (a): Facility policy [A 1] states that the agency shall provide multiple internal methods to privately report sexual abuse and sexual harassment, retaliation by other residents or staff and staff neglect or violation of responsibilities that may have contributed to such incidents. A resident may report these issues by verbally telling a staff member and/or by using the facility's grievance process. Interviews with residents indicate that they understand their reporting options as a result of PREA education, posters, and signage. Signage during the facility tour was noted by the Auditor. The Auditor reviewed the Facility PREA Video, staff training curriculum, the Resident Orientation Handbook and noted multiple internal ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse, sexual harassment and staff neglect or violation of responsibilities.

Subsection (b): Facility policy [A 2] identifies at least one way for residents to privately and anonymously

report sexual abuse of sexual harassment to an external entity not affiliated with the agency identified as the Texas Juvenile Justice Department (TJJD) abuse reporting phone line and/or to the Taylor County Sheriff's Department. The TJJD toll-free phone number and the phone number to the Taylor County Sheriff's Department are found on PREA posters throughout the facility common areas and housing areas. Residents are not detained at this facility solely for civil immigration purposes. Interviews with residents demonstrate they understand they can call the hotline and how to request staff to allow them to use the phone.

Subsection (c): Facility policy [A 4] requires facility staff to accept reports made verbally, in writing, anonymously, and from third parties and required to immediately, without delay report any verbal reports or a witness statement. Staffs are required to follow~~s~~ mandatory reporting duties. Interviews with facility staff and residents indicate their knowledge of this requirement.

Subsection (d): Facility policy [A 3] requires that residents shall have access to tools necessary to make a written report. Grievance forms are available from staff members and available in common areas. Facility policy requires staff will ensure blank grievance forms are available at all times to residents. The Auditor observed grievance forms and grievance deposit boxes during the tour of the facility housing units and common areas. Interviews with residents demonstrated their understanding of the available reporting mechanisms such as the grievances.

Subsection (e): Facility policy [A 5] provides that staff can privately report sexual abuse and sexual harassment of residents by reporting to their local law enforcement, TJJD, direct supervisor, shift supervisor, facility administrator or to the PREA Coordinator. Any such report must be immediately reported to the Facility Administrator. Interviews of random staff demonstrated their understanding these reporting mechanisms available to them.

Corrective Action: None.

Standard 115.352 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy Chapter 6 Section VII 115.352 Exhaustion of administrative remedies
3. Grievance Forms available at facility website : **http://www.taylorcountytexas.org/525/Reporting-Abuse**
4. Resident Orientation Handbook
5. Interviews with the following:
    a. No Resident had reported sexual abuse
6. Observation of resident grievance forms and grievance boxes located in facility programs, housing units and programming areas during tour of physical plant

Findings (By Subsection):

Subsection (a): The facility has an administrative procedure for dealing with resident grievances regarding sexual abuse and is not exempt from this standard.

Subsection (b): Facility policy [B (1-2)] allows a resident to submit a grievance regarding an allegation of sexual abuse at any time regardless of when the incident is alleged to have occurred. Residents are not required to comply with the grievance procedures involving informal attempts to resolve issues for any grievance alleging sexual abuse or sexual harassment. Residents are not required to try to resolve with staff an alleged incident of sexual abuse. The Auditor reviewed the Resident Orientation Handbook and confirmed that no time limits are imposed on when a resident may submit a grievance regarding an allegation of sexual abuse.

Subsection (c): Facility policy [B (3 a-b)] prohibits the facility from requiring residents to submit a grievance alleging sexual abuse or sexual harassment to a staff member who is the subject of the complaint. The facility shall not refer the grievance to the individual who is the subject of the complaint. The facility policy is compliant with this subsection. The Auditor reviewed the Resident Orientation Handbook and noted that a grievance may be submitted a grievance without submitting it to a staff member who is the subject of the complaint and the grievance is not referred to a staff member who is the subject of the compliant

Subsection (d): Facility policy [B 4] requires a decision on the merits of a grievance alleging sexual abuse or sexual harassment within 90 days of the initial filing of the grievance as required by this subsection. The policy complies with the requirements of this subsection relating to an extension of timeframes and denial in the absence of a response.

Subsection (e): Facility policy[B 5-6] permits third parties, including fellow residents, staff members, family members, attorneys, etc. to assist residents in filing requests for administrative remedies as required by this subsection. The policy complies with the requirements of this subsection. There had been no third party reports of sexual abuse or sexual harassment.

Subsection (f): Facility policy [B-8] provides for an emergency grievance procedure for residents to report situations involving imminent risk of sexual abuse of a resident. Policy is compliant with the requirements of the subsection regarding timelines for resolution. The emergency grievance procedure is explained during the resident comprehensive education component. The resident education materials (i.e., handbooks, orientation documents) discuss PREA and the grievance procedure. There had been no emergency grievances filed.

Subsection (g): Facility policy [B- 9] states that it may discipline a resident for filing a grievance related to alleged sexual abuse only where the facility demonstrates that the resident filed the grievance in bad faith. The facility had no documented instances of discipline of residents for bad faith grievances.

Corrective Action: None

Standard 115.353 Resident access to outside confidential support services

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

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.

Evidence Reviewed (documents, interviews, site review):

1. Facility Policy Chapter 6 Section VII 115.353 Resident Access to Outside Support Services and Legal Representation
2. Agency agreement between the Taylor County Juvenile Board and the NOAH Project of Abilene
3. Agency agreement between the Taylor County Juvenile Board and the Betty Hardwick Center of Abilene
4. Youth Admission Pamphlet (English and Spanish) –TCJJC Comprehensive PREA Education for Residents"
5. Resident Detention Handbook (English and Spanish)
6. PREA Video
7. Facility PREA posters
8. Interviews with the following:
    a. Random Residents
    b. Residents who Reported a Sexual Abuse
    c. Interim Deputy Chief of Secure Facilities
    d. Telephone interview with the Program Director, NOAH Project of Abilene
    e. Executive Director of the Betty Hardwick Center
    f. PREA Coordinator
9. Observation of signage and educational materials on display in facility programs (secure and non-secure), housing units and programming areas during tour of physical plant

Findings (By Subsection):

Subsection (a): Facility policy [C 1] provides that residents have access to outside victim advocates for emotional support services related to sexual abuse. Residents are informed of these services during the comprehensive education training and through signage in living units. Interviews with residents indicate that the youth understand how to access these services, who provides these services or what these services include. The one (1) resident who alleged sexual abuse was transported to Hendricks Medical Center and was provided with a NOAH victim advocate.

Subsection (b): Facility policy [C 2] provides that staff inform residents that conversations and written correspondence may be monitored and the extent to which reports of abuse will be provided to appropriate authorities in accordance to existing laws. Interviews with residents indicate that the youth were aware when communications regarding reports of abuse were to be forwarded related to mandatory reporting laws.

Subsection (c): Facility policy provides that the facility have agreements with community service providers for confidential emotional support for residents related to sexual abuse. The Taylor County Juvenile Services Department has agreements with the Betty Hardwick Center of Abilene and the NOAH Project of Abilene. The Auditor reviewed both agreements and spoke to both organizations which confirmed the agreement to provide the services required by this standard.

Subsection (d): Facility policy [C 4] provides residents with reasonable and confidential access to their attorneys or other legal representatives and reasonable access to parents or legal guardians. Interviews with the Interim Deputy Chief of Secure Facilities and residents indicate the facility complies with these requirements.

Standard 115.354 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy Chapter 6 Section VII 115.354 Third Party reporting
3. Taylor County Juvenile Services Juvenile, Parent, Community Grievance Report Form
4. **Facility website at: http://www.taylorcountytexas.org/525/Reporting-Abuse**

Findings (By Subsection):

Subsection (a): Facility policy [D (1 a-c)] establishes mechanisms to receive third-party reports of sexual abuse and sexual harassment and to distribute publicly information on how to report sexual abuse and sexual harassment on behalf of a resident. Third parties can file a grievance on behalf of a resident and allege sexual abuse or sexual harassment. The Taylor County Juvenile Services Department website contains information on how to report as required by this standard.

Corrective Action: None.

Standard 115.361 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire
2. Facility Policy Chapter 6 Section VIII 115.361 Staff and agency reporting duties
3. Interviews with the following:
    a. Random Staff
    b. Medical and Mental Health Staff
    c. PREA Coordinator
    d. Interim Deputy Chief of Secure Facilities

Findings (By Subsection):

Subsection (a): Facility policy [A (1 a-c)] requires staff to immediately report any knowledge, suspicion or information received regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency, retaliation against residents or staff who reported an incident and any staff neglect or violations of responsibilities that may have contributed to an incident or retaliation. Interviews with random staff demonstrate their knowledge of their reporting responsibilities under Texas law, facility policy and PREA regulations.

Subsection (b): Facility policy [A 2] requires all staff to comply with mandatory child abuse reporting laws. Random staff interviews confirmed their responsibility to comply with facility policies and mandatory child abuse reporting laws.

Subsection (c): Facility policy [A 3] requires that apart from reporting to the designated supervisors or officials and designated State or local services agencies, all staff shall maintain that information in confidence except as necessary to make treatment/investigation and other security/management decisions. Interviews with random staff knew the limitations to which they were prohibited from revealing any information related to a sexual abuse report.

Subsection (d): Facility policy [A 4] requires medical and mental health staff to report abuse to designated supervisors and officials, as well as to the designated State or local services agency where required by mandatory reporting laws. Medical and mental health practitioners are required to inform residents of the limitations of confidentiality of their duty to report and the limitations of confidentiality. Interviews with medical and mental health staff confirm compliance with this standard relating to protection of confidential information and required disclosures.

Subsection (e): Facility policy [A (6-8)] requires the facility administrator or designee to promptly (within 1 hour of receipt) report the allegation to the Taylor County Sheriff's Department, TJJD, and the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified. If the victim is under the guardianship of DFPS the report shall be made to the caseworker instead of the parents or legal guardians. The allegation will also be reported to the victim's attorney or the youth's Juvenile Probation Officer within 14 days of receiving the allegation. Interviews with the PREA Coordinator and Interim Deputy Chief of Secure Facilities confirm practice follows policy.

Subsection (f): Facility policy [A 9] requires the facility to report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators. Interview with the Interim Deputy Chief of Secure Facilities confirmed this is the practice.

Corrective Action: None.

Standard 115.362 Agency protection duties

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

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.

Evidence Reviewed (documents, interviews, site review):

1. Facility Policy Chapter 6 Section VIII 115.362 Agency protection duties
2. Interviews with the following:
    a. Interim Deputy Chief of Secure Facilities
    b. Random Staff

Findings (By Subsection):

Subsection (a): Facility policy [B 1] requires that when staff learns that a resident is subject to a substantial risk of imminent sexual abuse, they take immediate action to protect the resident. Staff shall take action to assess and implement appropriate protective measures without unreasonable delay. The first responder will take steps to separate the alleged victim from the alleged perpetrator. The alleged staff or resident abuser will not have contact with the victim. The PAQ documents that there have been no instances of this in the past 12 months. Interviews demonstrate all necessary actions to protect the resident would be taken

Corrective Action: None.

Standard 115.363 Reporting to other confinement facilities

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

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.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy Chapter 6 Section VIII 115.363 Reporting to other confinement facilities
3. Interviews with the following:
    a. Facility Head
    b. Interim Deputy Chief Secure Facilities

Findings (By Subsection):

Subsection (a): Facility policy [C 1] requires that upon receiving an allegation that a resident was sexually abused while in another confinement facility, the Facility Administrator must notify the administrator of the facility or appropriate office of the agency where the alleged abuse occurred and shall notify the appropriate investigative agency. The PAQ documents that the facility reports that there have been zero (0) allegations of this type received in the past 12 months. Further the PAQ also states that the facility has received no notifications from other facilities in the past 12 months. Interviews with the Interim Deputy Chief Secure Facilities indicated that this policy would be followed if such situation occurred.

Subsection (b): Facility policy [C 2] requires that such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegations.

Subsection (c): Facility policy [C 3] requires that the Facility Administrator will document the notification and also notify TJJD.

Subsection (d): Facility policy [C 4] states that should the facility receive such notification, it shall ensure the allegation is investigated in accordance with policy. Interviews with the Interim Deputy Chief Secure Facilities confirm knowledge of this policy and stated that the policy would be followed should this situation occur.

Corrective Action: None.

Standard 115.364 Staff first responder duties

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

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.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy Chapter 6 Section VIII 115.364– Staff first responder duties
3. Staff training documents – training on first responder duties and responsibilities
4. Facility First Responder laminated card
5. Interviews with the following:
    a. Security Staff and Non-Security Staff First Responders
    b. Residents Who Reported a Sexual Abuse
    c. Random Staff

Findings (By Subsection):

Subsection (a): Facility policy [D (1 a-d]] correctly identifies first responder duties upon receiving an allegation that a resident was sexually abused as required by this standard. The PAQ documents that there have been no allegations of sexual abuse in the facility during the past 12 months. Interviews with staff demonstrated their knowledge of the first responder protocol. The facility has provided staff with first responder cards that staff can carry in their duty belt to use when responding to an incident. Interviews with staff indicate an understanding of their first responder duties and an ability to articulate and explain the duties correctly.

Subsection (b): Facility policy [D (1 e]] distinguishes the first responder duties for security staff versus non-security staff. All facility Juvenile Supervision Officers are first responders. Interviews with random staff confirmed knowledge of their responsibilities.

Corrective Action: None.

Standard 115.365 Coordinated response

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

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.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy Chapter 6 Section VIII 115.365 Coordinated response
3. Facility Written Institutional Plan
4. Taylor County PREA First Responders Checklist and Coordinated Response poster.
5. Interview with Facility Director
6. Interviews with the following:
    a. Interim Deputy Chief of Secure Facilities
    b. PREA Coordinator

Findings (By Subsection):

Subsection (a): Facility policy [E 1] explains the manner in which the facility's coordinated written institutional response plan operates to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership. Interviews with the Interim Deputy Chief Secure Facilities and PREA Coordinator confirmed the details of the written plan.

Corrective Action: None.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

☐ Not Applicable

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.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy Chapter 6 Section VIII 115.361 Preservation of ability to protect residents from contact with abusers
3. Interviews with the following:
    a. Chief Juvenile Probation Officer

Findings (By Subsection):

Subsection (a): Taylor County Juvenile Services policy [F 1] states that it does not participate in any collective bargaining agreements. It does not enter into or renew any agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted.

Subsection (b): N / A

Corrective Action: None.

Standard 115.367 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy Chapter 6 Section VIII 115.367 Agency Protection Against Retaliation
3. Agency Form 115.367 Sexual Abuse Retaliation Monitoring – to be used in instances of retaliation for reporting sexual abuse incidents
4. Interviews with the following:
    a. Interim Deputy Chief of Secure Facilities charged with monitoring against retaliation
    b. Supervisor charged with monitoring against retaliation

Findings (By Subsection):

Subsection (a): Facility policy [G 2] states that the facility shall protect all residents and staff who report sexual abuse or sexual harassment or cooperates with an investigation from retaliation by other residents or staff. The facility policy also states that appropriate measures will be taken, to include contacting the Sheriff's Department, to protect the individual against retaliation. An agency administrator and four (4) facility supervisors had been designated to monitor against retaliation.

Subsection (b): Facility policy [G 1 (a-c)] states that the facility employs multiple protection measures such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abuser from contact with victims, and emotional support services for residents or staff that fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations. Staff could articulate to the auditor the ways they would uncover retaliation and monitor retaliation. Interviews with staff charged with monitoring for retaliation stated that there have been zero (0) instances of alleged retaliations in the past 12 months.

Subsection (c): Facility policy [G 2 (a-f)] requires the facility to continue monitoring for retaliation for at least 90 days following a report with a possible extension beyond 90 days if needed in compliance with this subsection. Facility policy also requires that the facility employ multiple protection measures such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abuser from contact with victims, and emotional support services for residents or staff that fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations. Administrators and staff were knowledgeable about the duty to monitor for retaliation for the time periods in this standard as well as required procedure. The PREA Coordinator stated that she even monitored for retaliation in the instance of the one (1) resident who incorrectly filed a PREA allegation (determined by TJJD) to be a facility grievance and was not related to sexual abuse or sexual harassment.

Subsection (d): Facility policy [G 2] requires that for residents, such monitoring shall also include periodic

status checks to be conducted by the Shift Supervisors. Status checks will be conducted randomly and documented.

Subsection (e): Facility policy [G 4] states that if any other individual who cooperates with an investigation expresses a fear of retaliation, the agency shall take appropriate measures protect that individual against retaliation.

Subsection (f): Facility policy [G 3] the obligation to monitor shall terminate if the investigation determines the allegation is unfounded.

Corrective Action: None.

Standard 115.368 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy Chapter 6 Section VIII 115.368 [H] Post-allegation protective custody
3. Interviews with the following:
    a. Interim Deputy Chief of Secure Facilities
    b. Medical and Mental Health Staff
    c. Staff who Supervise Residents in Isolation

Findings (By Subsection):

Subsection (a): Facility policy [H 1] provides that the use of segregated housing to protect a resident who is alleged to have suffered sexual abuse shall be subject to the requirements of Standard 115.342. T he PAQ documents that in the past 12 months there have been no residents who have alleged sexual abuse who were placed in isolation. The Auditor observed no residents in post-protective custody during the on-site audit tour. Staff interviews indicate that if isolation is ever used, the protections required by Standard 115.342 would be followed.

Corrective Action: None.

Standard 115.371 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy Chapter 6 Section IX 115.371 [A] Criminal and administrative agency investigations
3. MOU between the Taylor County Juvenile Services Department and the Taylor County Sheriff's Department
4. Interviews with the following:
    a. Investigative Staff
    b. Interim Deputy Chief Secure of Facilities
    c. PREA Coordinator
    d. Taylor County Sheriff's Office Representative

Findings (By Subsection):

Subsection (a): This facility policy [A 4] requires the agency to conduct administrative investigations. The Taylor County Sheriff's Department conducts criminal investigations into allegations of sexual abuse and sexual harassment. Facility policy requires these investigations to be conducted promptly, thoroughly and objectively for all allegations, including third party and anonymous reports. The PAQ documents that the facility reports two (2) allegations in the past year. The first allegation was referred to Taylor County Sheriff's Office and reported to the TJJD. During the first investigation by the Sheriff's Office and while the resident was awaiting a SANE examination, the resident recanted the allegation. Although the resident recanted the allegation, the investigation was completed and determined to be unfounded. The resident was subsequently notified of the outcome of the investigation. Interviews with agency staff confirmed that the allegation, the administrative/criminal investigation, and the referral to Taylor County Sheriff's Department completed the investigation. The second allegation was referred to the TJJD resulted in a finding that the referral was not an issue of sexual abuse or sexual harassment rather, it was determined to be a resident grievance. The Auditor reviewed both investigation reports and concurred with the findings. In the prior 12 months, there had been zero (0) allegations received by the facility that a resident was abused while confined at another facility. Administrative investigations must also follow the administrative rules promulgated by the Texas Juvenile Justice Department contained in Title 37 Texas Administrative Code Chapters 358.

Subsection (b): The facility policy [A 5] requires all facility investigators to have special training in sexual abuse investigations involving juvenile victims per Standard 115.334. The facility investigator has received specialized investigator training from the Texas Juvenile Justice Department. The interview with the investigator confirmed completion of this training and could articulate the key components of the course related to investigations in correctional settings. The Auditor reviewed the specialized training completion document issued by the TJJD.

Subsection (c): The facility policy [A 6] requires investigators to gather and preserve evidence, interview appropriate persons and review prior complaints involving the alleged perpetrator as required by this subsection. The interview with investigative staff demonstrates knowledge of how to conduct investigations of this type.

Subsection (d): The facility policy [A 1] prohibits the facility from terminating an investigation solely because the source of the allegation recants the allegation. Interviews with investigators confirmed their understanding of this requirement. The Auditor reviewed the investigation during which the resident recanted her allegation and observed that the investigation was completed even though the resident recanted her allegation.

Subsection (e): The facility policy [A 7] prohibits investigators from conducting compelled interviews in certain situations. The policy states that when the quality of evidence appears to support criminal prosecution, the facility shall conduct compelled interviews only after consulting with prosecutors. The interview with the facility investigator confirmed his understanding of this requirement.

Subsection (f): The facility policy [A 8] requires investigators to assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the person's status as a resident or staff. The policy requires the investigation to proceed and a polygraph examination cannot be used as a condition for proceeding with the investigation. There had been no investigations which utilized a polygraph examination or any other truth-telling device. The interview with the facility investigator confirmed his understanding of this requirement.

Subsection (g): The facility policy [A 2] requires administrative investigations to include an effort to determine whether staff actions or failures to act contributed to the abuse. Additionally, facility policy requires investigators to document the investigation in written reports that include descriptions of the evidence, the reasoning behind credibility assessments, and investigative facts and findings. The interview with the facility investigator confirmed his understanding of this requirement.

Subsection (h): The facility policy [A 3] requires that investigations shall be documented per TJJD incident form requirements and investigation requirements including:

a. Description of the physical, testimonial and documentary evidence,
b. The reasoning behind credibility assessments, and
c. Investigative facts and findings.

Subsection (i): The facility policy [A 9] requires investigators to refer for prosecution substantiated allegations of conduct that appear to be criminal. There have been zero (0) substantiated allegations of conduct that appeared to be criminal. The interview with the facility investigator confirmed there had been zero (0) substantiated allegations and those allegations which appear to be criminal would be referred for prosecution by the Taylor County Sheriff's Department.

Subsection (j): The facility policy [A 10] requires that all written reports of administrative and criminal investigations shall be retained 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.

Subsection (k): The facility policy [A 11] states that the departure of the alleged abuser or victim from the employment or control of the facility shall not provide a basis for terminating an investigation. The interview with the facility investigator confirmed his understanding of this requirement.

Subsection (l): The facility policy [A 11] requires that any State entity or Department of Justice component that conducts such investigations shall do so pursuant to the above requirements. Interviews with facility investigators confirmed that TJJD investigations follow the PREA standards.

Subsection (m): The facility policy [A 12] requires the facility to cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation. Interviews with staff indicate that the facility maintains close contact with TJJD and Taylor County Sheriff's Department who conduct external investigations. Interviews with the facility investigator, Interim Deputy Chief of Secure Facilities and the PREA Coordinator confirmed their understanding of this requirement.

Corrective Action: None.

Standard 115.372 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy Chapter 6 Section IX 115.372 [B] – Evidentiary standard for administrative investigations
3. Interview with the following:
    a. Investigative Staff

Findings (By Subsection):

Subsection (a): Facility policy [B 1] states that it will impose no standard higher than a preponderance of evidence or a lower standard of proof for determining whether allegations of sexual abuse or sexual harassment are substantiated. The interview with the facility investigator confirmed his knowledge of the required standard of proof and that the practice would be to use "preponderance of the evidence" in facility investigations.

Corrective Action: None.

Standard 115.373 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy Chapter 6 Section IX 115.373 [C] Reporting to residents
3. Resident Allegation Notification Form
4. Interviews with the following:
    a. Interim Deputy Chief Secure Facilities
    b. Investigative Staff

Findings (By Subsection):

Subsection (a): The facility policy [C 1] requires that any resident who makes an allegation that he or she suffered sexual abuse in the facility shall be informed verbally or in writing, of all notifications, as to whether the allegation has been determined to be substantiated, unsubstantiated or unfounded following an investigation by the agency. Each resident who made an allegation of sexual abuse were notified of the investigation findings. The interviews with the Interim Deputy Chief Secure Facilities and facility investigator indicated that the notifications required under this section would be provided as a part of all investigations. The Auditor reviewed the investigation reports of the allegations and noted that each resident had been informed verbally and in writing.

Subsection (b): The facility policy [C 2] requires that relevant information will be requested from external investigators if the facility did not conduct the investigation in order to notify the resident. The PAQ documented that there had been two (2) external investigations conducted in the past 12 months by the Taylor County Sheriff's Department or TJJD on PREA related conduct. The Auditor reviewed documentation to confirm both residents had been notified as required.

Subsection (c): Facility policy [C 1 (a-d)] requires notification of the resident when 1) the staff member is no longer posted within the resident's unit; 2) the staff member is no longer employed at the facility; 3) the staff member has been indicted; 4) or the staff member has been convicted on a charge related to sexual abuse within the facility.

Subsection (d): The facility policy [C 1 (e)] requires the facility to provide notification to the resident (regarding abuse by another resident) when the abuser has been indicted or the abuser has been convicted on a charge related to sexual abuse within the facility.

Subsection (e): The facility policy [C 2] requires the facility to document all such notifications or attempted notifications under this standard.

Corrective Action: None.

Standard 115.376 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy Chapter 6 Section X 115.376 [A] Disciplinary sanctions for staff.

Findings (By Subsection):

Subsection (a): The facility policy [A 1] provides that staffs that violate facility sexual abuse or sexual harassment policies are subject to disciplinary sanctions up to and including termination as required by this

standard.

Subsection (b): The facility policy [A 2] provides that the facility shall terminate staff members found to have engaged in sexual abuse. In the past 12 months, the facility reports that no staff has violated the facility policy on sexual abuse or sexual harassment. No staff have been terminated, disciplined or resigned for PREA related conduct and no reports of staff misconduct/criminal behavior have been made to law enforcement.

Subsection (c): The facility policy [A 3} requires disciplinary sanctions to be commensurate with the nature and circumstances of the acts committee, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. In the past 12 months, the facility reports that no staff has violated the facility policy on sexual abuse or sexual harassment.

Subsection (d): The facility policy [A 4] requires the facility to report all terminations for violations of policy on sexual abuse or sexual harassment, or resignations by staff that would have been terminated, if not for their resignation to TJJD, relevant licensing bodies and the Taylor County Sheriff's Department, unless the activity was clearly not criminal. In the past 12 months, the facility reports that no staff has violated the facility policy on sexual abuse or sexual harassment.

Standard 115.377 Corrective action for contractors and volunteers

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

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.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy Chapter 6 Section X 115.377 [B] Corrective Action for Contractors and Volunteers
3. Interviews with the following:
    a. Interim Deputy Chief of Secure Facilities

Findings (By Subsection):

Subsection (a): The facility policy [B 1] states that the facility shall prohibit any contractor or volunteer, who engages in sexual abuse, from contact with residents and shall report to TJJD, local law enforcement agencies (unless not criminal conduct) and to relevant licensing bodies as required by this standard. In the past 12 months, the Facility reports that no contractors or volunteers have been reported to law enforcement for engaging in sexual abuse of residents.

Subsection (b): The facility policy [B 2] requires the facility to take appropriate remedial measures against a volunteer or contractor who violates the facility sexual abuse or sexual harassment policies. Contact with residents will be prohibited. The interview with the Interim Deputy Chief Secure Facilities indicated that no volunteer or contractor had violated the facility sexual abuse or sexual harassment policies.

Corrective Action: None.

Standard 115.378 Disciplinary sanctions for residents

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

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.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy Chapter 6 Section X 115.378 [C] Disciplinary sanctions for residents
3. Interviews with the following:
    a. Interim Deputy Chief of Secure Facilities

Findings (By Subsection):

Subsection (a): The facility policy [C 1] provides that a resident may be disciplined after a substantiated finding in an administrative investigation or a criminal finding that a resident participated in the sexual abuse of another resident or staff in compliance with this standard. The PAQ documents that there have been no administrative or criminal findings regarding resident on resident sexual abuse that have occurred in the facility in the past 12 months.

Subsection (b): The facility policy [C 2] requires any disciplinary sanctions for residents to consider the nature and circumstances of the abuse, the resident's disciplinary history, the sanctions imposed for comparable offenses by other residents with similar histories, and whether a resident' mental disabilities or mental illness contributed to his or her behavior. The policy requires that if isolation is used, the resident must be provided certain protections (i.e., educational programming, large-muscle exercise, medical/mental health visits) as detailed by this subsection which are all contained in the policy. An interview with Interim Deputy Chief of Secure Facilities confirm his knowledge of the requirements of this standard related to resident discipline and acknowledge that practice would be followed in such an event.

Subsection (c): The facility policy [C 3] requires the discipline process to consider whether a resident's mental disabilities or mental illness contributed to his or her behavior. The interview with the Interim Deputy Chief of Secure Facilities indicated this is the procedure.

Subsection (d): The facility policy [C 4] provides that the facility offers therapy and counseling for the resident. Participation in therapy of counselling is not required to access general programming or education services. Interviews with medical and mental health staff indicated that no resident had engaged in sexual abuse at the facility and that the resident would be offered therapy and counseling as required.

Subsection (e): The facility policy [C 5] prohibits the facility from disciplining a resident for sexual contact with staff unless the staff member did not consent to such contact.

Subsection (f): The facility policy [C 6] provides that a report of sexual abuse made in good faith shall not constitute a false report for disciplinary purposes.

Subsection (g): The facility policy [C 7] prohibits all sexual activity between residents and disciplines residents.

Corrective Action: None.

Standard 115.381 Medical and mental health screenings; history of sexual abuse

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

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.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy Chapter 6 Section XI 115.381 [A] Medical and mental health screenings; history of sexual abuse
3. Facility Screening for Risk of Sexual Victimization and Abusiveness Form
4. Interviews with the following:
    a. Residents who Disclose Sexual Victimization at Risk Screening
    b. Staff Responsible for Risk Screening
    c. NOAH Program Manager

Findings (By Subsection):

Subsection (a): The facility policy [A 1] requires the facility to offer a resident that has experienced prior sexual victimization a follow-up meeting with medical or mental health practitioners within 14 days of the intake screening. There were eight (8) residents during screening who disclosed prior sexual victimization while in the community. A review of the resident records demonstrated that all reports of prior sexual victimization had been previously reported to the State of Texas Child Protection Agency. All eight (8) residents had been offered a follow-up meeting as required. Resident interviews indicate follow-up medical and mental health care (counseling) is offered should residents wish to talk about their victimization with their counselors. The Auditor interviewed the NOAH Program Manager who stated that confidential mental health secondary materials are maintained at that organization by trained crisis counselors that all residents who had experienced prior sexual victimization were offered services and referred to appropriate services in the community. Interviews with staff who conduct the screening indicate that these follow-up services are provided.

Subsection (b): The facility policy [A 2] requires the facility to offer a resident that has previously perpetrated sexual abuse a follow-up meeting with medical or mental health practitioners within 14 days of the intake screening. There were four (4) residents who disclosed previous sexual abuse perpetration. Three (3) of those residents were at the facility less than 24 hours. The forth was currently enrolled in counseling services with MHMR and under treatment by that agency. Interviews with staff who conduct the screening indicate that follow-up services had been provided to all four (4) residents. A review of four (4) resident records confirmed that the services had been offered upon intake screening. The Betty Hardwick counselors maintain confidential mental health secondary materials are not available to facility staff.

Subsection (c): Facility policy [A 3] requires staff to keep information related to sexual victimization or abusiveness confidential. Resident information in the Texas Juvenile Justice Department JCMS system is confidential through role-based security.

Subsection (d): The facility policy [A 4] states that medical and mental health practitioners shall 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. Interviews with medical and mental health staff confirm the requirement shall be followed.

Corrective Action: None.

Standard 115.382 Access to emergency medical and mental health services

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

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.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy Chapter 6 Section XI 115.382 [B] Access to emergency medical and mental health services
3. MOU Hendricks Medical Center
4. MOU with NOAH Project of Abilene
5. Interviews with the following:
    a. Medical staff
    b. Resident who Reported a Sexual Abuse
    c. First Responders

Findings (By Subsection):

Subsection (a): The facility policy [B 1] provides that resident victims of sexual abuse shall receive timely unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgement. Emergency medical services (SANE) are to be provided at Hendricks Medical Center, while crisis intervention services are to be provided by the NOAH Project of Abilene. Interviews with medical staff confirm this is the practice. There had been one (1) resident who reported a sexual abuse incident. The resident refused emergency medical services and recanted the allegation. The allegation was investigated by the Taylor County Sheriff's Office and determined the allegation to be unfounded. There have been zero (0) resident victims of sexual abuse.

Subsection (b): The facility policy [B 2] provides if no qualified medical or mental health practitioners are on duty at the time of a report of recent abuse is made, the first responder shall take preliminary steps to protect the victim pursuant to PREA standard 115.362 and shall immediately notify the appropriate medical and mental health practitioners. The facility PAQ documents that there have been no allegations of sexual abuse in the previous 12 months that would require emergency medical treatment or crisis intervention services. Interviews with medical staff demonstrated their knowledge of first responder protocols for acute cases of sexual abuse.

Subsection (c): The facility policy [B 3] requires the facility to offer resident victims of sexual abuse timely information about and timely access to emergency contraception and sexually transmitted infection

prophylaxis, in accordance with professional accepted standards of care, and where medically appropriate. The Auditor reviewed the MOU with the Hendricks Medical Center and the NOAH Project of Abilene. Interviews with administrators at the Hendricks Medical Center and the NOAH Project of Abilene confirm their responsibilities. Interviews with medical and mental health confirm that this would occur at the local Medical Centers where the resident would be transported.

Subsection (d): The facility policy [B 4] provides that it shall offer these treatment services (under this standard) 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. Interviews corroborate that victims are not charged for these treatment services. The Auditor reviewed the MOU with the Hendricks Medical Center and confirmed services are provided a without financial cost.

Corrective Action: None.

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

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

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.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy Chapter 6 Section XI 115.383 [C] On-going medical and mental health care for sexual abuse victims and abusers
3. Interviews with the following:
    a. Medical and Mental Health staff
    b. There was one (1) residents who Reported a Sexual Abuse

Findings (By Subsection):

Subsection (a): The facility policy [C 1] provides that the facility shall offer medical and mental health evaluation and, as appropriate, treatment to all residents who are victims of have been victimized by sexual abuse in prison, jail, lockup, or juvenile facility. There was one (1) resident who had reported sexual abuse. During the investigation by the Taylor County Sheriff's Department, the resident recanted the allegation. The allegation was determined to be unfounded. No medical or mental health care services were provided.

Subsection (b): The facility policy [C 2] provides the evaluation and treatment of such victims 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. Interviews with the medical and mental health staff confirmed that such victims are provided follow-up services, treatment plans and necessary referrals for continued care.

Subsection (c): The facility policy [C 3] provides that the facility shall provide such victims with medical and mental health services consistent with the community level of care. Interviews with the medical and mental health staff confirmed that such victims are provided required services.

Subsection (d): The facility policy [C 4] provides that the facility shall offer pregnancy tests to resident victims of sexually abusive vaginal penetration that occurs while they are resident of any facility. There were no female residents who reported sexual victimization.

Subsection (e): The facility policy [C 5] provides that if pregnancy results from a sexual assault, resident victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services. Interviews with the medical and mental health staff confirmed that such victims are provided required services. There were no residents who had reported a sexual abuse.

Subsection (f): The facility policy [C 6] requires that tests for sexually transmitted infections, as medically appropriate, will be offered to resident victims of sexual abuse that occurs while they are residents of any facility. There were no residents who had reported a sexual abuse.

Subsection (g): The facility policy [C 7] requires that all treatment services are provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. There were no residents who had reported a sexual abuse.

Subsection (h): The facility policy [C 8] requires an attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 14 days of learning of such abuse history and shall offer treatment when deemed appropriate by mental health. Interviews with the medical and mental health staff confirmed that such victims are provided required services and are offered these services upon learning of abuse upon the resident's intake process upon admission.

Corrective Action: None.

Standard 115.386 Sexual abuse incident reviews

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

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.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy Chapter 6 Section XII 115.386 [A] Sexual Abuse Incident Reviews
3. Interviews with the following:
    a. Interim Deputy Chief of Secure Facilities
    b. Incident Review Team Member

Findings (By Subsection):

Subsection (a): The facility policy [A 1] requires a sexual abuse incident review to be conducted at the conclusion of every sexual abuse investigation, including incidents where there was not enough evidence to substantiate the allegation, unless the investigation shows the allegation is unfounded. The facility reports

that in the past 12 months, there have been two (2) sexual abuse investigations, both of which were unfounded. Interviews with Interim Deputy Chief of Secure Facilities and Incident Review Team member indicate their knowledge and understanding of the sexual abuse incident review process as required.

Subsection (b): The facility policy [A 2] requires the review to occur within 30 days of the conclusion of the investigation.

Subsection (c): The facility policy [A 3] provides that the review team shall include upper- level management officials; Chief Probation Officer, Deputy Chief of Fiscal Services, Administrative Designee, PREA Coordinator, Facility Administrator and Administrative Assistant with input from line supervisors, investigators and medical or mental health practitioners. Interview with the Interim Deputy Chief of Secure Facilities confirmed the parties of the review team.

Subsection (d): The facility policy [A 4 (a-f)] requires that the review team shall consider:

(a) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse;

(b) Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or, gang affiliation; or was motivated or otherwise caused by other group dynamic at the facility;

(c) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse (camera placement, blind spots, training curriculum, and program);

(d) Assess the adequacy of the staffing levels in that area during different shifts;

(e) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and

(f) Prepare a report of its findings, including but not limited to determination made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement and submit such report to the Chief Probation Officer, Facility Administrator and PREA Coordinator. Interviews with facility staff indicate the considerations in this subsection would be a part of the team review.

Subsection (e): The facility policy [A 4 (g)] requires that the Facility Administrator shall implement the recommendations for improvement, or shall document the reasons for not doing so.

Corrective Action: None.

Standard 115.387 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy Chapter 6 Section XII 115.387 [B] Data collection

3. PREA Annual Data Review and Corrective Action Plan dated May 17, 2016 for 2015 and 2016
4. Taylor County Juvenile Center PREA Data Collection January 17, 2017
5. TAYLOR COUNTY website: http://www.taylorcountytexas.org/527/PREA-Annual-Data-Review
6. Interviews with the following:
    a. Interim Deputy Chief of Secure Facilities
    b. PREA Coordinator

Findings (By Subsection):

Subsection (a) and (c): The facility policy [B 1-3] provides that it shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. The data shall 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 (DOJ). The Auditor reviews the data collection and aggregate report and determined compliance with this section.

Subsection (b): The facility policy requires it to aggregate the incident-based sexual abuse data at least annually. The Auditor reviewed aggregated incident-based sexual abuse data for calendar years 2015-2017. The data is found at http://www.taylorcountytexas.org/528/PREA-Annual-Data-Review-Chart.

Subsection (d): The facility policy [B 1-6] requires the facility to maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

Subsection (e): The agency policy [B 5] requires the facility to obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents. The facility has one (1) contact for the confinement of its residents in case of an emergency, but has not utilized the contract facility.

Subsection (f): The facility policy requires the facility, upon request, to provide all such data from the previous calendar year to the DOJ no later than June 30. The DOJ has not requested agency data as of the PREA on-site audit.

Corrective Action: None.

Standard 115.388 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy Chapter 6 Section XII 115.388 [C] Data review for corrective action 115.388
3. PREA Annual Data Review and Corrective Action Plan dated January 17, 2017 http://www.taylorcountytexas.org/528/PREA-Annual-Data-Review-Chart

4. Interviews with the following:
    a. Chief Juvenile Probation Officer
    b. Interim Deputy Chief of Secure Facilities
    c. PREA Coordinator

Findings (By Subsection):

Subsection (a): The facility policy [C 1 (a-c) requires the facility to review data collected and aggregated under Standard 115.387 annually to assess and improve the effectiveness of sexual abuse prevention, detection, and response policies, practices, and training including: a.) identifying problem areas; b) taking corrective action on an ongoing basis; and c) preparing an annual report for each facility and the department as a whole. Interviews with Facility Administration indicate this process is in place as required by this standard. Interviews with Facility Administration indicate their knowledge of the data review required by this section and they articulated appropriately and effectively how they will use this process to improve their overall PREA compliance and the sexual safety of the facility. The Auditor reviewed the data collected and aggregated and noted the annual report had been prepared as required on January 17, 2017. Interviews with the Chief Juvenile Probation Officer and PREA Coordinator confirmed the data collection and aggregation processes occur annually.

Subsection (b): The facility policy [C 2] requires the report to include a comparison of the current year's data and corrective actions with those from prior years and shall provide an assessment of the facility's progress in addressing sexual abuse. The Auditor reviewed the facility's PREA Data Collection which documents data comparisons from 2015-2016.

Subsection (c): The facility policy [C 3] requires the agency head to approve the report and make it readily available to the public through the Taylor County website. The Auditor verified the data and report approved and posted on the facility website: http://www.taylorcountytexas.org/528/PREA-Annual-Data-Review-Chart

Subsection (d): The facility policy [C 4] states that the department will redact any specific information from the reports when publication of such information would present a clear and specific threat to the safety and security of the facility. The Taylor County Juvenile Justice Department shall indicate the nature of the material redacted (when applicable). An interview with the PREA Coordinator indicated that the agency has presently not needed to redact any information from the report that would present a clear and specific threat to the safety and security of the facility, but would do so as required by agency policy.

Corrective Action: **None.**

Standard 115.389 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy Chapter 6 Section XII 115.389 [D] - Data storage, publication, and destruction
3. PREA Annual Data Review and Corrective Action Plan dated May 17, 2017

4. TAYLOR COUNTY website: http://www.taylorcountytexas.org/528/PREA-Annual-Data-Review-Chart
5. Interview with the following:
    a. PREA Coordinator

Findings (By Subsection):

Subsection (a): The facility policy [D 1] requires that it to ensure that all data collected pursuant to Standard 115.387 are securely retained. The interview with the facility PREA Coordinator confirmed compliance with this standard.

Subsection (b): The facility policy [D 2] requires it to make all aggregated sexual abuse data from facilities under its direct control, and private facilities with which it contracts, readily available to the public through the Taylor County website on an annual basis. The Auditor reviewed the data on the website cited above to confirm compliance with this subsection.

Subsection (c): The facility policy [D 3] requires it to remove all personal identifiers prior to making aggregated sexual abuse data publicly available. The Auditor reviewed the aggregated data and noted that no personal identifiers were present.

Subsection (d): The facility policy [D 4] requires that unless Federal, State or local laws requires, the department shall maintain all abuse data collected pursuant to PREA Standard 115.387 for at least 10 years after the date of its initial collection.

Corrective Action: None.

AUDITOR CERTIFICATION

I certify that:

☒ The contents of this report are accurate to the best of my knowledge.

☒ No conflict of interest exists with respect to my ability to conduct an audit of the facility under review, and

☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Glen E. McKenzie, Jr — August 22, 2017

Auditor Signature — Date