

## Prison Rape Elimination Act (PREA) Audit Report Juvenile Facilities

Interim       Final

Date of Report    July 14, 2019

### Auditor Information

Name: Ana T. Aguirre	Email: ata3consulting@gmail.com
Company Name: ATA3 Consulting, LLC	
Mailing Address: PO Box 19748	City, State, Zip: Austin, TX 78760
Telephone: 512-708-0647	Date of Facility Visit: Oct. 29 – Nov. 1, 2018

### Agency Information

Name of Agency		Governing Authority or Parent Agency (If Applicable)	
Travis County Juvenile Probation Department		Travis County Juvenile Board	
Physical Address: 2515 South Congress Avenue		City, State, Zip: Austin, TX 78704	
Mailing Address: 2515 South Congress Avenue		City, State, Zip: Austin, TX 78704	
Telephone: 512-854-7000		Is Agency accredited by any organization? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
The Agency Is:	<input type="checkbox"/> Military	<input type="checkbox"/> Private for Profit	<input type="checkbox"/> Private not for Profit
<input type="checkbox"/> Municipal	<input checked="" type="checkbox"/> County	<input type="checkbox"/> State	<input type="checkbox"/> Federal
Agency mission: Provides for public safety while addressing the needs of juvenile offenders, families, and victims of crime; and assists parents in collecting and distributing court-ordered child support.			
Agency Website with PREA Information: <a href="https://www.traviscountytexas.gov/juvenile-court">https://www.traviscountytexas.gov/juvenile-court</a>			

### Agency Chief Executive Officer

Name: Estela P. Medina	Title: Chief Juvenile Probation Officer
Email: estela.medina@traviscountytexas.gov	Telephone: 512-854-7000

### Agency-Wide PREA Coordinator

Name: Kris Johnson	Title: Casework Manager
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<b>Email:</b> kris.johnson@traviscountytexas.gov	<b>Telephone:</b> 512-854-1851
<b>PREA Coordinator Reports to:</b> Chris Hubner, General Counsel	<b>Number of Compliance Managers who report to the PREA Coordinator</b> 3

### Facility Information

<b>Name of Facility:</b> Muerer Intermediate Sanctions Center (ISC) / Shelter
<b>Physical Address:</b> 2515 South Congress Avenue, Austin, TX 78704
<b>Mailing Address (if different than above):</b> 2515 South Congress Avenue, Austin, TX 78704
<b>Telephone Number:</b> 512-854-7000

<b>The Facility Is:</b>	<input type="checkbox"/> Military	<input type="checkbox"/> Private for Profit	<input type="checkbox"/> Private not for Profit
<input type="checkbox"/> Municipal	<input checked="" type="checkbox"/> County	<input type="checkbox"/> State	<input type="checkbox"/> Federal
<b>Facility Type:</b>	<input type="checkbox"/> Detention	<input checked="" type="checkbox"/> Correction	<input type="checkbox"/> Intake
			<input type="checkbox"/> Other

**Facility Mission:** To protect the community from delinquency, impose accountability for offense committed, and to equip juvenile offenders with the required competencies to live productively and responsibly in the community.

**Facility Website with PREA Information:** <https://www.traviscountytexas.gov/juvenile-court>

**Is this facility accredited by any other organization?**  Yes  No

### Facility Administrator/Superintendent

<b>Name:</b> Cory Burgess	<b>Title:</b> Director of Residential Services
<b>Email:</b> cory.burgess@traviscountytexas.gov	<b>Telephone:</b> 512-854-7076

### Facility PREA Compliance Manager

<b>Name:</b> Leslie Dudek	<b>Title:</b> Accreditation and Compliance Officer
<b>Email:</b> leslie.dudek@traviscountytexas.gov	<b>Telephone:</b> 512-854-5615

### Facility Health Service Administrator

<b>Name:</b> Melissa Unterseher	<b>Title:</b> Interim Medical Supervisor
<b>Email:</b> melissa.unterseher@traviscountytexas.gov	<b>Telephone:</b> 512-854-5633

### Facility Characteristics

Designated Facility Capacity: 118		Current Population of Facility: 32	
Number of residents admitted to facility during the past 12 months			31
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 10 days or more:			29
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:			29
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:			0
Age Range of Population:	13-18		
Average length of stay or time under supervision:			144
Facility Security Level:			ISC: Maximum; Halfway House: Minimum
Resident Custody Levels:			ISC: Maximum; Halfway House: Minimum
Number of staff currently employed by the facility who may have contact with residents:			78
Number of staff hired by the facility during the past 12 months who may have contact with residents:			89
Number of contracts in the past 12 months for services with contractors who may have contact with residents:			6
<b>Physical Plant</b>			
Number of Buildings: 2		Number of Single Cell Housing Units: 78	
Number of Multiple Occupancy Cell Housing Units:		20	
Number of Open Bay/Dorm Housing Units:		0	
Number of Segregation Cells (Administrative and Disciplinary):		0	
Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.):			
A new camera system is being installed. The old system is very limited and currently only tracks movement in the corridors and main access points to the facility. There are no cameras in the housing units.			
<b>Medical</b>			
Type of Medical Facility:		Health clinic with 24-hour nurses to provide medical care for minor health conditions, access to on-call physicians, and physician and dentist onsite at least once a week.	
Forensic sexual assault medical exams are conducted at:		If there is direct knowledge of sexual abuse within 120 hours of the assault, the on-duty nurse will contact SafePlace (Eloise House) for instructions to transport the resident to the	

	<p>appropriate hospital/location for a forensic exam by an appropriately qualified individual with the preference being a SAFE/SANE practitioner. Locations are available at Eloise House, St. David's and Dell Children's Hospital.</p>
<b>Other</b>	
<b>Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:</b>	25
<b>Number of investigators the agency currently employs to investigate allegations of sexual abuse:</b>	10

# Audit Findings

## Audit Narrative

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

The Prison Rape Elimination Act (PREA) onsite audit of the Muerer Intermediate Sanctions Center (ISC) / Shelter Post-Adjudication Facility in Austin, Texas, was conducted on October 29 to November 1, 2018 by Ana T. Aguirre, ATA3 Consulting, LLC. The facility is under the jurisdiction of the Travis County Juvenile Board. The pre-adjudication facility is adjacent to the post-adjudication and shelter facilities, and the juvenile probation office.

During the onsite audit, Ms. Aguirre toured the post-adjudication facility program and operational areas, including common areas shared with the pre-adjudication facility, which were minimal. The auditor noted, because of the type of services provided, any allegation of sexual abuse or sexual harassment will be reported to at least one of the following state agencies: Texas Juvenile Justice Department (TJJD), Department of Family Protective Services (DFPS), and the Department of State Health Services (DSHS).

### Pre-Audit Phase

The agency initiated the process to access the Online Audit System (OAS) on 8/14/18, secured access on 8/28/18 and submitted the completed PAQ on 9/13/18 for review by the auditor. The auditor held a meeting with staff from the Accreditation and Compliance Unit on 8/20/18 to discuss logistics and access to the facility, set goals and expectations, and set timelines. In preparation for the meeting, the auditor provided the PREA Audit Resource information for juvenile facilities, excerpts from the Auditor Handbook, and the Request for Information Regarding PREA Incidents and Investigations. The facility responded to the Request for Information on 10/19/18

The auditor emailed the PREA Audit Notices (English and Spanish) and posting instructions to the facility on 8/28/18. The notice included information advising the residents their letters would be treated as legal mail by TCJPD. The facility posted the required PREA Audit Notices on 9/14/18, which met the required six-week posting prior to the first day of the onsite audit. The agency provided emailed documentation, including pictures, to demonstrate the notices were posted in accordance with PREA Audit requirements. The posting documentation provided were for the following areas: visitation, main lobby, infirmary, female resident's dorm, male resident's dorm, and staff break room. During the onsite audit, the auditor noted the notices were posted in the following areas: each housing unit, library, classrooms, medical (infirmary), visitation, and both dining rooms. The notices were printed in bright pink neon color to ensure they stood out from the regular posted information throughout the facility. The agency agreed to maintain the posted notices a minimum of six weeks after the onsite audit. The auditor did not receive any correspondence as a result of the posted notices at any time during the pre-audit or post-onsite audit phases.

The pre-audit preparation phase included a review of all documentation, materials, and data submitted by the facility in the completed Pre-Audit Questionnaire (PAQ) via the Online Audit System (OAS). The documentation reviewed included agency policies and procedures; forms; organizational charts; PREA related posters, brochures; training documentation for staff, volunteers and contractors; and interagency

collaborative agreements. The auditor also contacted Just Detention International (JDI) to ensure this facility had no reports with their agency. JDI reported there were no reports regarding this agency.

As it pertains to policies, the pre and post-adjudication facilities share the following Agency-wide Administrative Services (AS) Policies, which include the following: AS-901 Chapter: Abuse and Neglect Prevention and Response; Subject: Reporting of Child Abuse, Neglect and Exploitation; AS-902 Chapter: Abuse and Neglect Prevention and Response; Subject Preventing and Detecting Sexual Abuse and Harassment; AS-905 Chapter: Abuse and Neglect Prevention and Response; Subject: Services for Victims of Sexual Abuse; AS-906 Chapter: Abuse and Neglect Prevention and Response; Subject: Incident Reviews and Data Collection; and AS-209 Chapter: Personnel; Subject: Code of Ethics/Staff- Juvenile Relationships.

On 10/10/18, the auditor requested the following facility lists, which included instructions on which information would be needed prior to arrival onsite and which information would be needed upon arrival onsite: complete resident roster; rosters of residents with disabilities, residents who are Limited English Proficient (LEP), residents who are Lesbian, Gay, Bisexual, Transgender or Intersex (LGBTI), residents in isolation, residents who reported sexual abuse, and residents who reported sexual victimization during screening; complete staff roster; rosters of specialized staff, and contractors and volunteers who have contact with residents; and lists of grievances, incident reports, allegations of sexual abuse and sexual harassment, and hotline calls. The facility provided staff, contractors and volunteer rosters on 10/19/18, which allowed the auditor to make a preliminary list of staff to interview while onsite.

The auditor completed an internet research and review of the agency's website for PREA information on 10/29/18. The auditor did not receive any correspondence from residents or staff during the pre-onsite audit phase.

#### **Onsite-Audit Phase**

An entrance interview with agency leadership, including Estela P. Medina, Chief Juvenile Probation Officer; Cory Burgess, Division Director of Residential Services; Kris Johnson, PREA Coordinator; and Leslie Dudek, PREA Compliance Manager; was held on Monday, October 29, 2018. A total of 14 staff were in attendance during the entrance interview. The pre-audit preparation and onsite audit processes were reviewed with the staff.

The auditor toured the facility and observed the following areas: the facility's configurations; location of cameras; staff to resident ratios; housing unit layout including the shower areas; placement of PREA related information; resident intake, and admission procedures; resident programming; and areas designated for staff support/operational areas. There is no formal designated 'intake area' in the facility. Residents meeting the treatment program criteria and placed by the courts are transferred directly from the pre-adjudication facility. When a resident candidate for the program is identified and considered for placement, the intake process is initiated by the intake staff. This allows the resident candidate and his family to ask and have their questions answered regarding the program's treatment goals. The auditor participated in a mock-intake to allow the intake staff to fully explain the intake process. Once accepted into the program, the case manager maintains the resident's case file, and treatment staff maintain the treatment records. Medical records are maintained by medical staff in the medical unit. Medical staff reported the medical record follows the resident from the pre-adjudication facility and they are allowed to see residents privately without an officer present.

At the time of the onsite audit, the current population stood at 32 residents, which included 31 male residents and 1 female resident. The auditor noted five of the ten units in ISC were not occupied, and four of the remaining five were vacant due to the residents participating in the required educational programming. Each housing unit included the required PREA Audit Notices, which were printed in hot pink colored paper and separate from other posted information. The required PREA information reinforcing the zero-tolerance of all sexual abuse and sexual harassment, including how to report such incidents was posted in the housing

units. When entering the female unit (shelter), staff made a verbal announcement that male staff were entering the unit. When entering the male units, even if there was a possibility a male resident might be on the unit, staff would verbally announce female staff were entering the unit. The one unit that had a male resident in isolation for behavioral issues had one staff assigned to provide supervision. Each housing unit includes a day room and at least one central restroom/shower area allowing residents privacy. Residents are only allowed to shower one at a time and are not permitted to enter another resident's cell. Each unit includes a 'timeout room,' which is used on a minimal basis for residents when they encounter behavioral issues. The day room are also utilized for chapel/religious services. There are no cameras in the housing units. The current camera system is very limited and only tracks movement in the corridors and main access points to the facility. The auditor observed all remaining residents were in the classrooms, with assigned supervision officers in the classrooms as the educational instructors delivered their respective educational information. The PREA information and audit notices were posted in the academic educational classrooms but not in the vocational classroom. The auditor requested the PREA information also be posted in the vocational classroom. The auditor noted the library included the posted PREA information and audit notices. The auditor conducted informal interviews with staff and residents during the onsite review and arranged her schedule to allow for onsite observation of each shift.

The facility operates treatment focused programming. Group treatment meetings are held and conducted in the individual housing units. The individual treatment needs of the residents are identified, and residents are assigned to the housing unit with the appropriate treatment programming that best meets the needs of the resident. Residents participate in group, family and individual treatment services. Residents are provided the required educational services. Eligible residents also have access to the Residential Services Education/Vocational Skills Training Program, which provides the following training programs: Food Handler Certificates, Mechatronics, Pre-Apprentice Electrical, Building Maintenance, Core Construction, Small Engine Repair, and Job Readiness/Life Skills.

While onsite, and as a result of the department reporting the very recent approval of the new Regional Diversion Placement Program, the auditor included in the site review the designated additional six housing units located on the wing joining the pre-adjudication and post-adjudication facilities. At the time of the onsite audit, three of the six units were occupied by pre-adjudication residents, but for the purposes of this audit, the auditor did not interview or include in the population count the residents under the care and control of the pre-adjudication program operations. Both pre and post-adjudication populations are kept separate at all times. The auditor noted all the units had the required PREA audit notices and PREA related information posted.

The auditor conducted an onsite review of the front entrance and visitation areas and noted the PREA audit notices were posted. The medical clinic allows for medical services 24/7 and includes a dental exam room and one standard exam room. A night-time nurse is primarily assigned to the pre-adjudication facility but is available as needed. Medical staff reported they do not conduct forensic medical exams and the facility is not equipped to conduct such exams.

The facility has two dining rooms and one kitchen. Residents are not allowed in the food preparation or kitchen area. Both dining rooms had the PREA information and audit notices prominently posted. The gym was vacant at the time of the onsite review but did have the PREA audit notices posted. A mechanical room is adjacent to the gym and staff reported the door is secured and residents do not have access to it. The outdoor recreation yard was not being used during the onsite review and had cameras strategically placed to allow for the view of the entrance points to the recreation yard. The auditor was provided access to the laundry, warehouse (storage) and the facilities maintenance areas. The auditor informally interviewed laundry staff and maintenance staff, who reported they do not come into contact with residents.

During the onsite audit phase, the auditor was provided a meeting space to conduct confidential interviews with administrative staff. The auditor was provided access to the library to conduct confidential interviews

with residents and security staff. Formal interviews were conducted with facility staff, residents, contractors, volunteers, and interns.

The auditor formally interviewed 11 residents from all of the occupied housing units; and over 29 staff, of which 11 were agency specialized staff, and four contractors and volunteers. The auditor also interviewed two SAFE/SANE agency staff, one outside criminal investigator and one staff member from JDI.

The random sample of staff were interviewed from the following shifts:

- 6:00 AM – 2:00 PM – 1 female; 3 male staff
- 2:00 PM – 10:00 PM – 1 female; 3 male staff
- 10:00 PM – 6:00 AM – 2 females; 2 male staff

The auditor utilized the PREA Resource Center Interview Protocols while formally interviewing staff and residents. Staff interviews included, but were not limited to, the following topics: their knowledge of the PREA zero tolerance policy on sexual abuse and sexual harassment; PREA related training received; reporting requirements, including reporting mechanisms available to residents and staff; their general knowledge of detection and protective measures related to sexual abuse and sexual harassment; and response/first responder protocols.

Resident interviews included, but were not limited to, the following topics: their knowledge of the PREA zero tolerance policy on sexual abuse and sexual harassment; their rights not to be sexually abused or sexually harassed, prohibited conduct and discipline; PREA related education received; their knowledge on reporting options available to them proper protection and response to allegation of sexual abuse or sexual harassment; not fearing retaliation for reporting; access to an outside reporting agency, their attorney, and parents or legal guardians; and access to services.

#### Interview and File Selection Methodology

##### Resident Selection – Interviews:

Using the resident roster, the first and last names listed in each housing unit were randomly selected. Adjustments were made to ensure the residents’ race, ethnicity, and age were considered for diversity. Also considered were housing and cell assignments. The auditor included the name of the targeted resident roster list. That name was identified in the main roster list and prioritized over randomly selected residents for an interview.

##### Resident Selection – Files (Onsite and Post-Onsite Audit):

All of the randomly and targeted residents selected to be interviewed had their files reviewed. A total of 15 residents files were reviewed. For each resident file requested, the auditor requested intake screening, classification, resident education, medical and mental health information (PREA related), sexual abuse and sexual harassment incidents, and reassessment (reclassification) records. The following resident categories were selected for interviews and corresponding files were selected:

<b>Targeted Resident Category</b>	<b>Number Reported or Identified</b>	<b>Number Interviewed</b>	<b>Number Files Selected for Review</b>
Random Residents	32	10	13
Targeted Residents	1	1	2*
<b>Breakdown of Required Targeted Interviews</b>			
Residents with Physical Disability			

Residents who are Blind, Deaf, or Hard of Hearing		0	0	0
Residents who are LEP		0	0	0
Residents with a Cognitive Disability		0	0	0
Residents Who Reported Sexual Abuse		1	1	2*
LGBTI Identified Residents	Residents Identified as Transgender	0	0	0
	Residents Identified as Bi-Sexual		0	0
	Residents Identified as Gay		0	0
Residents Who Disclosed Prior Sexual Victimization During Risk Screening		0	0	0
Residents in Segregated Housing for High Risk of Sexual Victimization		0	0	0

\*A prior resident reported a prior sexual abuse incident that allegedly occurred in another institution. The resident's file was selected and reviewed, specifically to ensure the follow-up medical and mental health services were offered. The file reflected the resident was referred and provided medical and mental health services, including being offered victim advocacy services.

**Investigative Files (Onsite and Post-Onsite Audit):**

During the pre-onsite audit phase, the auditor requested the agency provide data between November 2017 and October 2018. The auditor reviewed both sexual abuse and sexual harassment files reported in the past 12 months. The following is a breakdown of the sexual abuse and sexual harassment allegations reviewed by the auditor. The records were reviewed for more than one purpose, based on the applicable provision (e.g., third-party report resulted in a sexual abuse investigation and subsequent incident review was conducted).

Allegations: Sexual Abuse	1
Sexual Harassment	1
Grievances	0
Hotline Calls	0
Third-party Reports	2 (1 by resident; 1 by staff)
Investigations: Sexual Abuse	1
Sexual Harassment	1
Dispositions: Administrative Cases Substantiated	2 (1 sexual abuse; 1 sexual harassment)
Incident Reviews: Sexual Abuse	1
Sexual Harassment	1

**Staff Selection – Interviews:**

Using the Daily Staff Assignments Roster, the first name listed under the housing unit was randomly selected. Adjustments were made to ensure race/ethnicity, sex, job position, and tenure were considered in the selection process for diversity. Also considered were shift and post assignments. The auditor identified specialized staff that would be interviewed based on their roles and responsibilities. One staff member was interviewed for more than one interview protocol, based on their role and responsibility. Security direct-care staff were randomly selected from all three shifts and based on their availability. In a few circumstances, a backup name was selected when the first selection was not available for an interview.

Staff Selection – Files (Onsite and Post-Onsite Audit):

Files were requested for all randomly selected staff interviewed, and all were provided. The auditor requested a total of 15 random staff files and five specialized staff files. Some files were reviewed for more than one purpose, based on the applicable provision (e.g., random staff hired in the past 12 months and completed PREA training).

	Total Numbers	Number Interviewed	Number Files Reviewed
Facility Staff	81		
Administrative Staff		4	1
a. Agency Head – CJPO			
b. Superintendent - Division Dir. of Residential Services			
c. PREA Coordinator			
d. PREA Compliance Manager			
Random Staff		12	13
Specialized Staff		13	6
Outside SAFE/SANE and Victim Advocacy Staff		2	
Hired in Past 12 Months	13	5	8
Promoted in Past 12 Months	1	1	1
Specialized Staff Listed Below:			
Agency Contract Administrator	1	1	0
Intermediate/Higher-Level Staff	1	1	0
Administrative (Human Resources) Staff	1	1	0
Investigative Staff	10	2	3
Medical Staff	17	1	2
Mental Health Staff	13	1	3
Intake Staff	1	1	0
Staff that perform Screening for Risk of Victimization and Abusiveness	1	1	0
Staff who Supervise Residents in Isolation	All Residential Supervision Officers	1	0
Incident Review Team Staff	8	1	0
Staff who have acted as First Responders	2	1	1
Staff Charged with Monitoring Retaliation	Residents – Residential Treatment Officers Staff – Shift Supervisors and Unit Coordinators	1	0
Volunteers	20	2	4
Contractors	6	2	2
Grievance Staff	1	1	1

An exit interview was conducted on Thursday, November 1, 2018, with agency leadership. Nine additional agency and facility staff were also in attendance. The auditor provided a brief preliminary summary of the onsite audit process and the next steps that would take place during the post-onsite audit phase.

### **Post-Onsite Audit Phase**

The auditor completed the review of the employee, resident and investigative files during the post-onsite audit phase. Supplemental documentation, including revised forms, were provided by agency staff as requested by the auditor. A follow-up meeting was held with agency staff on 4/17/19 to review and finalize the corrective action milestones. Additional interviews were conducted and additional file information was secured during this time. The auditor did not receive any correspondence from residents or staff during the post-onsite audit phase.

## **Facility Characteristics**

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

The Muerer Intermediate Sanctions Center (ISC) / Shelter Post-Adjudication Facility is located at 2515 South Congress Avenue in Austin, Texas. The facility is under the Residential Services Division and is one division of the Travis County Juvenile Probation Department. The Residential Services Division provides secure, long-term housing and care for post-adjudicated male and female juveniles between 13 – 18 years of age. At the time of the onsite audit, the current population stood at 32 residents, which included 31 male residents and 1 female resident. The agency reported 31 residents had been admitted to the facility in the past 12 months, with 29 residents whose length of stay in the facility was for 10 or more days, and 29 residents admitted to the facility whose length of stay in the facility was for 72 or more hours. The agency reported 78 employed staff at the facility during the past 12 months and 89 staff hired by the facility during the past 12 months who may have contact with residents. The agency reported six contracts with contractors who might have contact with residents and 25 volunteers and contractors currently authorized to enter the facility. The current camera system is very limited and only tracks movement in the corridors and main access points to the facility. There are no cameras in the housing units. The agency is pending the installation of a new camera system for the pre-adjudication and post-adjudication facilities.

The facility reported it contains two buildings: ISC and the Halfway House (Shelter). The facility's designed capacity is 118 beds for the ISC and 10 beds for the Halfway House (Shelter). The ISC is a three-story building with two floors designated to house residents. The third floor also includes the library and academic educational classrooms, and the first floor has the vocational educational programs. One floor is designated for probation staff and also includes the medical services department. The shelter is a one-story building. The ISC has 10 housing units, and the Shelter has one. Each housing unit has 10 single cells and includes a day room and a central restroom/shower. At the time of the onsite audit, the resident population included one female resident and 31 male residents for a total of 32 residents. The female resident was being housed at the shelter. The Shelter – Casa Mariposa, is designated to house only female residents. In the ISC, five of the 10 housing units were vacant. The occupied units reflected the following numbers of male residents: Unit 4 – seven residents; Unit 6 – five residents; Unit 7 – eight residents; Unit 8 – five residents; and Unit 9 – six residents.

While onsite, and as a result of the department reporting the very recent approval of the new Regional Diversion Placement Program, the auditor included in the site review the designated additional six housing units located on the wing joining the pre-adjudication and post-adjudication facilities. At the time of the onsite audit, three of the six units were occupied by pre-adjudication residents, but for the purposes of this audit, the auditor did not interview or include in the population count the residents under the care and control of the pre-adjudication program operations. Both pre and post-adjudication populations are kept separate at all times. The auditor noted all the units had the required PREA audit notices and PREA related information posted. Each of the housing units includes eight single cells, one shower/restroom area, and a dayroom. The auditor observed the preliminary preparation contract staff were undertaking for the new camera system. The pre-adjudication facility is scheduled for Phase One of the camera installation process.

The facility operates a health clinic with 24-hour nurses to provide medical care for minor health conditions, access to on-call physicians, and a physician and dentist on-site at least once a week. The clinic includes a dental exam room, a standard exam room and a small waiting area. Medical staff reported they do not conduct forensic medical exams and the facility is not equipped to conduct such exams.

The facility has two dining rooms and one kitchen. Both dining rooms were not in use at the time of the onsite review. The gym was vacant at the time of the onsite review and had a small mechanical room adjacent to it, which was locked. The outdoor recreation yard was also not in use during the onsite review and had cameras strategically placed to allow for a view of the entrance points to the recreation yard. The auditor was provided access to the laundry, warehouse (storage) and the facilities maintenance areas. Staff reported residents do not have access to these areas.

## Summary of Audit Findings

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

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

**Number of Standards Exceeded:** 1

115.311

**Number of Standards Met:** 41

115.311, 115.312, 115.313, 115.315, 115.316, 115.317, 115.318, 115.321, 115.322, 115.331, 115.332, 115.333, 115.334, 115.335, 115.341, 115.342, 115.351, 115.352, 115.353, 115.354, 115.361, 115.362, 115.363, 115.364, 115.365, 115.366, 115.367, 115.368, 115.371, 115.372, 115.373, 115.376, 115.377, 115.378, 115.381, 115.382, 115.383, 115.386, 115.387, 115.388, 115.389

**Number of Standards Not Met:** 0

N/A

### Summary of Corrective Action (if any)

115.312: The agency provided a revised list of contracts, which included the PREA audit status for each facility.

115.351: The agency revised the resident handbook to include residents can also report retaliation by other residents or staff for reporting sexual abuse and sexual harassment and staff neglect or violation of responsibilities that may have contributed to such incidents. The revised handbook includes the contact information for SafePlace.

115.353: The MOU was modified to include the provision for emotional support services related to sexual abuse.

115.361: The agency revised the *TCJPD Internal Investigation Checklist* Form to include an additional subsection documenting the notification of the alleged victim's attorney within 14 days, if the victim is under the juvenile court's jurisdiction.

115.367: The agency created and implemented the Retaliation Monitoring Form for the purpose of monitoring, tracking, and documenting retaliation.

115.387: The agency secured the incident-based aggregated data from the facilities it contracts with for the confinement of its residents, including the public facilities.

115.389: The agency secured the incident-based aggregated data from the facilities it contracts with, including the public facilities. The agency will provide, on its website, the links to the private facilities' websites or make the data available by some other means.

## PREVENTION PLANNING

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

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

#### 115.311 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment?  Yes  No
- Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment?  Yes  No

### 115.311 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator?  Yes  No
- Is the PREA Coordinator position in the upper-level of the agency hierarchy?  Yes  No
- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities?  Yes  No

### 115.311 (c)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

### The following evidence was analyzed in making the compliance determination:

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
  - b. AS-901 Reporting of Child Abuse, Neglect, and Exploitation (*revised 12/1/16*)
  - c. AS-902 Preventing and Detecting Sexual Abuse and Sexual Harassment (*revised 6/12/17*)
  - d. AS-209 Code of Ethics Staff – Juvenile Relationships (*revised 2/6/15*)
  - e. AS-905 Services for Victims of Sexual Abuse (*revised 2/19/16*)
  - f. Travis County Juvenile Probation General Administration Organizational Chart (*dated FY18 July 2018*)

2. Interviews:
  - a. PREA Coordinator
  - b. PREA Compliance Manager
3. Onsite Review:
  - a. Administrative Offices

### **Findings (By Provision):**

#### **115.311(a).**

In the PAQ, the agency reported it has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment. The facility reported it has a policy that outlines the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. The facility also reported the policy includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment, sanctions for those found to have participated in prohibited behaviors, and a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents.

Agency Policy AS-901 Reporting of Child Abuse, Neglect, and Exploitation, Section I (p. 1), and Section II (pp. 1-2) addresses the zero tolerance of sexual abuse and sexual harassment and the definitions of sexual abuse and sexual harassment. Agency Policy AS-902 Preventing and Detecting Sexual Abuse and Sexual Harassment, Section I (p. 1), and Section III (A, E, I, J and K) (pp. 2-5, and 7-8) addresses the zero tolerance of sexual abuse and sexual harassment, procedures to detect, prevent, report and respond to sexual abuse and sexual harassment. Agency Policy AS-209 Code of Ethics Staff – Juvenile Relationships, Section III (D.1) (p. 4) addresses staff discipline for the violation of the Code of Ethics. Agency Policy AS-905 Services for Victims of Sexual Abuse, Section I (p. 1), addresses the zero tolerance policy towards all forms of sexual abuse, sexual harassment and youth sexual conduct, and access to medical and mental health services, confidential victim advocacy services and referrals for continued care.

#### **115.311(b).**

In the PAQ, the agency reported It has employed an agency-wide PREA Coordinator that has sufficient time and authority to develop, implement, and oversee the agency's efforts to comply with the PREA standards in all of its facilities. The agency reported the position is designated within the Accreditation and Compliance Department. The agency's organizational chart reflects the position is in the upper-level of the agency's hierarchy and reports to the Agency's General Counsel who reports to the Agency's Chief Juvenile Probation Officer.

Agency Policy AS-902 Preventing and Detecting Sexual Abuse and Sexual Harassment, Section III (A) (pp. 2-3) addresses the designation of the department-wide PREA coordinator and outlines the position's responsibilities. Staff interviewed reported he feels he has enough time to manage all of the PREA related responsibilities. He reported there are always challenges managing the tasks related to the American Correctional Association (ACA), Texas Juvenile Justice Department (TJJD), and PREA audits, as well as health, property and risk management related inspections. He reported he supervises three PREA Managers. One is assigned to detention, and two are assigned to residential with one being the primary PREA Manager and the second a backup to the primary PREA Manager. During the onsite review, the auditor noted the PREA Coordinator has a designated office.

#### **115.311(c).**

In the PAQ, the agency reported it has designated two staff as PREA Managers for the facility that have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards. The facility reported the PREA Managers report to the PREA Coordinator. The agency's organizational chart reflects the position is in the upper-level of the agency's hierarchy and reports to the PREA Coordinator who reports to the Agency's General Counsel. The organization chart reflects three PREA Manager positions. One of the positions is designated for the pre-adjudication detention facility and the remaining two for the post-adjudication residential facility.

Agency Policy AS-902 Preventing and Detecting Sexual Abuse and Sexual Harassment, Section III (A) (pp. 2-3) addresses the designation of the PREA Manager for each facility and outlines the position's responsibilities. The primary PREA Manager was interviewed and reported she feels she had enough time to manage all of the PREA-related responsibilities. She reported she works with the other two PREA Managers and can divide duties and keep up with their PREA related responsibilities. During the onsite review, the auditor noted the PREA Managers' have designated offices.

**Corrective Action:**

1. The auditor recommends no corrective action.

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

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

**115.312 (a)**

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

**115.312 (b)**

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents OR the response to 115.312(a)-1 is "NO".)  Yes  No  NA

**Auditor Overall Compliance Determination**

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

## Instructions for Overall Compliance Determination Narrative

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

### The following evidence was analyzed in making the compliance determination:

#### 1. Documents:

- a. Pre-Audit Questionnaire (PAQ)
- b. AS-902 Preventing and Detecting Sexual Abuse and Sexual Harassment (*revised 6/12/17*)
- c. Original Contractual Agreements with the Following Entities
  - a. 4M Granbury Youth Services (*dated 11/15/10*)
  - b. Campbell A. Griffin Center (Cornell) (*dated 5/13/03*)
  - c. Gulf Coast Trades Center, Inc. (*dated 9-23-05*)
  - d. Hays Juvenile Justice Center (*dated 12/18/07*)
  - e. Kerr County Juvenile Detention (*dated 6/11/03*) (no longer in operation)
  - f. Pegasus Schools, Inc. (*dated 11/19/01*)
  - g. Phoenix House of Texas, Inc. (*dated 4/27/00*) (Substance Abuse Treatment Counseling)
  - h. Rockdale Regional Juvenile Justice (*dated 11/7/03*)
  - i. Shoreline Inc. (*dated 6/8/00*) (Drug Counseling)
  - j. Victoria County (*dated 1/7/08*)
- d. Amended Contractual Agreements with the Following Entities:
  - i. 4M Granbury Youth Services (*dated 11/20/12*)
  - ii. Cornell Corrections of Texas, Inc. (Gulf Coast Trade Center) (*dated 7/16/13*)
  - iii. Hays County Juvenile Center (*dated 7/16/13*)
  - iv. Hector Garza Center
  - v. Kerr County Juvenile Detention (*dated 4/25/13*) (no longer in operation)
  - vi. Pegasus Schools, Inc. (*dated 2/27/13*)
  - vii. Phoenix House of Texas, Inc. (*dated 4/27/00*) (Substance Abuse Treatment)
  - viii. Rockdale Regional Juvenile Justice (*dated 10/2/12*)
  - ix. Shoreline Inc. (*dated 4/25/13*) (Drug Counseling)
  - x. The Oaks Brownwood
  - xi. Victoria County (*dated 11/6/12*)
- e. Memo (*dated 1/10/19*)
- f. Contracted Facility List (*provided onsite 10/31/18*)

#### 2. Interviews:

- a. Agency's Contract Administrator

### Findings (By Provision):

#### 115.312(a).

In the PAQ, the agency reported it has entered into or renewed a contract for the confinement of its residents since the last PREA audit. The agency reported there were 10 contracts for the confinement

of residents that the agency entered into or renewed with private entities or other government agencies since the last PREA audit and that all of the contracts require contractors to adopt and comply with the PREA standards. Although the standard does not require policy, Agency Policy AS-902 Preventing and Detecting Sexual Abuse and Sexual Harassment, Section III (H.1) (p. 7) addresses new or renewed contract requirements will specify placement shall be fully compliant with the PREA Standards.

The agency provided copies of the original contractual agreements with 10 entities. The agency provided copies of modified contractual agreements with nine entities. A review of the 10 original contracts indicated two were the same facility. One of the facilities was no longer in operation and two facilities did not meet the criteria defined by juvenile facilities, as their primary services focus on drug counseling or substance abuse treatment counseling. A review of the contracts indicated all were entered into or renewed prior to the last PREA audit. It was determined the agency misreported the 10 contracts and has not entered into any new contractual agreements for the confinement of residents since the last PREA audit.

**115.312(b).**

In the PAQ, the agency reported all the contracts require the agency to monitor the contractor’s compliance with the PREA standards, and all of the 10 contracts require the agency to monitor the contractor’s compliance with the PREA Standards. Although the standard does not require policy, Agency Policy AS-902 Preventing and Detecting Sexual Abuse and Sexual Harassment, Section III (H.2) (p. 7) requires contracted placements will be reviewed on a regular basis for compliance with the PREA Standards.

Staff interviewed reported that when renewing a contract, she looks to see if the language requiring the contractor to comply with the PREA Standards is included. She added that when PREA came into effect, they were modified. She advised she provided a list of all the contractual agreements to include the original contract with the modified contract. She reported she tracks all contracts by end dates and all get reviewed and the new review process will require review every year. She was not aware if PREA compliance results had been completed for each contract.

The auditor inquired on the PREA compliance status of each entity for which the agency had contracted with for the confinement of its residents and a revised list was provided. The revised list reflected the following status for each contract in which the agency contracts for the confinement of its residents:

Contracted Facility	PREA Compliance Required	Last PREA Audit	Next PREA Audit	Number of TCJPD Youth at the Facility
1. 4M Granbury	Yes	9/8/17	9/8/20	2
2. Gulf Coast Trade Center	Yes	2/5/16	2/5/19	8
3. Hays County	Yes	6/29/16	6/29/19	0
4. Hector Garza Center	Yes	5/12/16	5/12/19	9
5. Pegasus	Yes	9/1/16	9/1/19	3
6. Rockdale	Yes	3/23/16	3/23/19	0
7. Oaks Brownwood	Yes	7/10/18	7/10/21	5
8. Victoria Regional	Yes	8/9/17	8/9/20	0

Upon further review, it was noted that one of the contracts (#4) was listed more than once as one had the name of the parent company instead of the name of the facility, plus the company/facility had undergone some name changes. All contracts did reflect the required PREA language. The auditor confirmed the facilities had either undergone a PREA audit or were pending the completion of PREA

audit. One contract (#7) provides residential services for external placements, and the agency is in the process of creating a formal contract. The agency reported (memo dated 1/10/19) the estimated timeline for creating a formal contract is approximately nine months. The facility with whom the contract was pending had undergone a PREA audit on 07/25/18, and the report reflected the facility met all 41 standards.

**Corrective Action:**

1. The agency provided a revised list of contracts, which included the PREA audit status for each facility.

**Standard 115.313: Supervision and monitoring**

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

**115.313 (a)**

- Does the agency ensure that each facility has developed a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?  Yes  No
- Does the agency ensure that each facility has implemented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?  Yes  No
- Does the agency ensure that each facility has documented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The prevalence of substantiated and unsubstantiated incidents of sexual abuse?  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Generally accepted juvenile detention and correctional/secure residential practices?  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any judicial findings of inadequacy?  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from Federal investigative agencies?  Yes  No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies?  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)?  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The composition of the resident population?  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The number and placement of supervisory staff?  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Institution programs occurring on a particular shift?  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any applicable State or local laws, regulations, or standards?  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any other relevant factors?  Yes  No

### 115.313 (b)

- Does the agency comply with the staffing plan except during limited and discrete exigent circumstances?  Yes  No
- In circumstances where the staffing plan is not complied with, does the facility document all deviations from the plan? (N/A if no deviations from staffing plan.)  Yes  No  NA

### 115.313 (c)

- Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.)  
 Yes  No  NA
- Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.)  
 Yes  No  NA

- Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A only until October 1, 2017.)  Yes  No  NA
- Does the facility ensure only security staff are included when calculating these ratios? (N/A only until October 1, 2017.)  Yes  No  NA
- Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph?  Yes  No

#### 115.313 (d)

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The staffing plan established pursuant to paragraph (a) of this section?  Yes  No
- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns?  Yes  No
- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The facility's deployment of video monitoring systems and other monitoring technologies?  Yes  No
- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan?  Yes  No

#### 115.313 (e)

- Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities)  Yes  No  NA
- Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities)  Yes  No  NA
- Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? (N/A for non-secure facilities)  Yes  No  NA

#### Auditor Overall Compliance Determination

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

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

### Instructions for Overall Compliance Determination Narrative

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

### The following evidence was analyzed in making the compliance determination:

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
  - b. AS-902 Preventing and Detecting Sexual Abuse and Sexual Harassment (*revised 6/12/17*)
  - c. RS-7.20 Supervision and Movement of Residents (*revised 3/9/18*)
  - d. RS 2016 Annual Staffing Plan (*reviewed 10/24/16*)
  - e. DS 2016 Annual Staffing Plan (*reviewed 10/24/16*)
  - f. RS 2017 Annual Staffing Plan (*reviewed 10/23/17*)
  - g. Daily Population Rosters (1/10/18, 4/10/18, 7/1/18, 7/10/18)
  - h. Unannounced Rounds reviewed, but not limited to the following:
    - a. February 7 (first shift), 9 (second shift), and 13 (third shift), 2018
    - b. March 28, 2018 (second shift)
    - c. April 10 (third shift) and 11 (first shift), 2018
2. Interviews:
  - a. Superintendent
  - b. PREA Coordinator
  - c. PREA Compliance Manager
  - d. Intermediate or Higher-Level Facility Staff
3. Onsite Review:
  - a. Throughout facility – housing units, common areas, hall corridors, and indoor/outdoor recreation areas.

### Findings (By Provision):

#### 115.313(a).

In the PAQ, the agency reported it ensures that each facility has developed a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse. The agency reported, the average daily number of residents is 33, and the average daily number of residents on which the staffing plan was predicated on was 128.

Although this provision of this standard does not require policy, Agency Policy AS-902 Preventing and Detecting Sexual Abuse and Sexual Harassment, Section III (A.5, E.5, and D) (*pp. 2-4*) addresses the annual effort to assess the facilities' staffing plans; at a minimum, the 11 factors outlined in Standard 114.313(a) that are considered in the review of the staffing plan; and ensuring the privacy of the residents by requiring staff of the opposite gender to announce their presence when entering the housing units. The facility's 2017 annual staffing plan addresses each of the 11 elements required of

this provision. The facility's rated capacity is 128: 118 for the secure portion of the facility; and 10 for the shelter. The facility's 2016 staffing plan, as well as the detention facility's 2016 staffing plan address all the required elements.

Staff interviewed reported the staffing plan is reviewed as a team, which reviews incidents, PREA complaints, staffing, and staffing ratios. Staff reported they are trying to decrease overtime, but will use it if needed to make sure the facility is adequately staffed. Staff also reported there is no video monitoring and the agency is currently in the process of installing a video monitoring system. The detention facility will have the equipment installed first, followed by the Gardner-Betts Courtroom. Staff reported they hope the residential facility will have the equipment installed in six months. They will have video capacity and will try to add audio capacity as well. When reviewing the staffing plan, staff reported they are audited and follow the TJJJD, ACA and PREA Standards, have not had any judicial findings of inadequacy or findings of inadequacy from internal or external oversight bodies. Staff reported they consider all components of the facility's physical plant, including blind spots, and that cameras will be installed soon. Staff added they consider the type of residents (offense history, size, stature, mental functioning, lifestyle, and victimization) and house accordingly based on a case-by-case basis. Staff consider the type of programs that will be operated and when they are in operation and the number and placement of supervisory staff. Staff reported they do consider incidents of sexual abuse and sexual harassment, and that although they have not had a lot of allegations, they consider the date, time, staff involved, and shifts to look for trends. Staff reported they check for compliance with the staffing plan throughout the day, during the night shift to see if staff conduct unannounced rounds. Staff reported the shift supervisor submits a daily schedule.

**115.313(b).**

In the PAQ, the agency reported there have been no deviations from the staffing plan. Staff interviewed reported they have always met the requirements and cannot think of any situation in which they would not.

**115.313(c).**

In the PAQ, the agency reported it is not obligated to maintain staffing ratios of a minimum of 1:8 during resident waking hours and 1:16 during resident sleeping hours, but reported it maintains staffing ratios of a minimum of 1:8 during resident sleeping hours and 1:16 during sleeping hours. Agency Policy RS-7.20 Supervision and Movement of Residents, Section III (B.1) (p. 3), outlines the required 1:8 staffing ratio during program hours, and 1:16 ratio during non-program hours. Staff interviewed reported TJJJD requires a 1:8 (waking) and 1:16 (sleeping) staffing ratios.

A review of the daily population rosters for 1/10/18, 4/10/18, 7/1/18, and 7/10/18, reflected the average daily population of 32. On 1/10/18, the overall resident population was 33, and the post orders reflected the assignment of 13 security staff (excluding supervisory staff) during the first shift. On 4/10/18, the overall resident population was 32, and the post orders reflected the assignment of 13 security staff (excluding supervisory staff) during the first shift. Additionally, the post orders reflected Unit 7 had five residents and two security staff during the first shift and on 4/10/18, Unit 7 had 10 residents and two security staff during the second shift. The post orders reflected the agency maintained a 1:8 staff to resident ratio(s) during waking hours.

**115.313(d).**

In the PAQ, the agency reported, at least once a year, in collaboration with the agency's PREA Coordinator, it reviews the staffing plan to see whether adjustments are needed.

Agency Policy AS-902 Preventing and Detecting Sexual Abuse and Sexual Harassment, Section III (D.10) (p. 4) states, “Resources will be made available to accommodate the adjustments of the staffing plan as indicated in the review.” Staff interviewed reported he is consulted regarding any assessments of, or adjustments to, the staffing plan. Staff reported that technically, he is the one who calls the staffing plan meeting once a year. He involves all staff, including Human Resources, Mental Health, Management, and Line Staff. The review involves updating for programs and currently trying to address blind spots in every housing unit, but having to wait.

**115.313(e).**

In the PAQ, the agency reported it has implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment.

Agency Policy AS-902 Preventing and Detecting Sexual Abuse and Sexual Harassment, Section III (E.4) (p. 4) requires the management team to conduct the unannounced rounds. The management team includes the Division Director, Division Manager, Casework Manager, and Shift Supervisors. The policy requires the unannounced rounds be made during all three shifts and be documented and prohibits staff from alerting other staff of the rounds unless it is related to legitimate operational functions of the facility. A review of the documented unannounced rounds reflected the rounds are conducted on all three shifts by management staff. Staff interviewed reported he had actually conducted an unannounced round earlier in the day. He reported he varies the times and does not have a set pattern, which prevents staff from alerting other staff that he is conducting an unannounced round. He reported he does document the unannounced rounds in the unit books. A review of documented unannounced rounds that were conducted reflects the unannounced rounds are randomly conducted and covered all three shifts.

**Corrective Action:**

1. After further review, the auditor recommended no corrective action.

**Standard 115.315: Limits to cross-gender viewing and searches**

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

**115.315 (a)**

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

**115.315 (b)**

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

**115.315 (c)**

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

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

#### 115.315 (d)

- Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks?  Yes  No
- Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit?  Yes  No
- In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units)  Yes  No  NA

#### 115.315 (e)

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status?  Yes  No
- If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner?  Yes  No

#### 115.315 (f)

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

#### Auditor Overall Compliance Determination

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

## Instructions for Overall Compliance Determination Narrative

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

### The following evidence was analyzed in making the compliance determination:

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
  - b. AS-902 Preventing and Detecting Sexual Abuse and Sexual Harassment (*revised 6/12/17*)
  - c. RS-7.20 Supervision and Movement of Residents (*revised 3/9/18*)
  - d. RS-6.120 Searches (*revised 6/8/15*)
  - a. AS-1203 LGBTQI Juveniles (*revised 12/1/16*)
  - e. TCJPD Training Record Update – PREA Cross Gender PAT Searches (dated 8/7/18, 8/14/18, 8/21/18, and 8/28/18)
2. Interviews:
  - a. Non-Medical Staff Involved in Cross-Gender Strip or Visual Searches
  - b. Random Sample of Staff
  - c. Random Sample of Residents
  - d. Transgender/Intersex Residents
3. Onsite Review:
  - a. Housing Units

### Findings (By Provision):

#### **115.315(a).**

In the PAQ, the agency reported it does not conduct any cross-gender strip or cross-gender visual body cavity searches and reported there were no cross-gender strip or cross-gender visual body cavity searches of residents conducted in the past 12 months.

Agency Policy RS-6.120 Searches, Section III (D.3-4) (*pp. 4-6*) addresses strip searches and anal or genital body cavity searches. Procedures require strip-searches will be conducted by a staff member of the same gender as the resident, and anal or genital body cavity searches will be conducted by a physician. The staff member witnessing the strip search will also be of the same gender and be approved by management staff prior to the search being performed. An anal or genital body cavity search requires approval by the CJPO or Assistant CJPO. All staff randomly interviewed regarding cross-gender strip or cross-gender visual body cavity searches reported these searches are not allowed, therefore this auditor did not interview any staff specific to this provision's interview protocol.

#### **115.315(b).**

In the PAQ, the agency reported it does not permit cross-gender pat-down searches absent exigent circumstances and reported there were no cross-gender pat-down searches of residents conducted in the past 12 months.

Agency Policy RS-6.120 Searches, Section III (D.1) (p. 3) addresses frisk or pat-down searches. Procedures require female staff will frisk search female residents, and male staff will frisk search male residents. The auditor interviewed 12 randomly selected staff from all three shifts. One of the staff had been hired within the past two weeks and was pending the completion of the training and reported being at the facility under constant supervision by a supervisor and currently participating in on-the-job training. With the exception of the newly hired staff, the remaining 11 staff reported cross-gender pat-down searches are not allowed. Four added it would be allowed only in exigent circumstances and two of the four reported they have been trained to conduct cross-gender pat-down searches in exigent circumstances. Eleven (10 male; one female) residents were interviewed, with nine of the residents randomly selected. All residents reported only male staff search male residents and female staff search female residents.

**115.315(c).**

In the PAQ, the agency reported agency policy does not require cross-gender strip searches, cross-gender visual body cavity searches, and cross-gender pat-down searches be documented and justified and also reported in the PAQ this provision is not applicable.

Agency Policy RS-6.120 Searches, Section III (D.2) (p. 3-4) addresses the procedures when searching residents in the Department of State Health Services (DSHS) licensed units, and Section III (D.3 and 4) (p. 4-5) addresses strip searches and anal or genital body cavity searches. These search procedures require documentation of these searches. Section III (D.1) (p. 3) addresses frisk or pat-down searches, but does not require documentation if a cross-gender pat-down search is conducted in the event of an exigent circumstance. Section III (D.3) (p. 4) states, "Strip searches will be conducted by a staff member of the same gender as the resident. Another staff member, also of the same gender of the resident, will be present as a witness to the search." The policy also requires strip searches be documented, plus requires the residential division manager, director of residential services, assistant CJPO, or CJPO review and approve the strip search prior to it being performed.

**115.315(d).**

In the PAQ, the agency reported it has implemented policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks. The agency also reported policies and procedures require staff of the opposite gender to announce their presence when entering a resident's housing unit.

Agency Policy RS-7.20 Supervision and Movement of Residents, Section III (A.4) (p. 2) requires same gender staff be the sole supervisors of residents during the following instances: (a) showers or performing bodily functions; (b) changing clothing or disrobing; (c) physical searches and pat-downs; (d) off-campus supervision, to include hospitalization; and (e) other instances requiring same gender supervision. Agency Policy AS-902 Preventing and Detecting Sexual Abuse and Sexual Harassment, Section III (E.5) (p. 5) requires staff of the opposite gender to announce their presence when entering the housing units.

The auditor interviewed 12 randomly selected staff from all three shifts. One of the staff had been hired within the past two weeks and was pending the completion of the training and reported being at the facility under constant supervision by a supervisor and currently participating in on-the-job training. With the exception of the newly hired staff, the remaining 11 staff reported opposite-gender staff knock and announce when entering a housing unit and would not be allowed in the housing unit while residents are showering. Two staff reported the signs are put up outside the door of the housing unit to

alert staff residents are showering. The shelter is designed to house only female residents. One staff member reported male staff are not assigned to the shelter and male staff do not oversee residents in the female units. Eleven (10 male; one female) residents were interviewed, with nine of the residents randomly selected. All residents reported opposite gender staff announce their presence when entering their housing area. All reported they are never naked in full view of opposite gender staff.

During the onsite review, the auditor noted magnetic signs are available for staff to post on the door to the entrance of the housing units when residents are showering. The auditor also noted opposite gender staff making verbal announcements when entering the housing units, except those that were not occupied or operational. Most of the units were vacant, because the residents were participating in educational programming. Each housing unit has a designated shower and toilet room and residents are allowed to use it one at a time.

**115.315(e).**

In the PAQ, the agency reported it has a policy prohibiting staff from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status. The agency reported no such searches occurred in the past 12 months.

Agency Policy RS-6.120 Searches, Section III (D.5) (p. 6) states, "Transgender or intersexed (sic) residents will not be searched or physically examined for the sole purpose of determining the resident's genital status." Agency Policy AS-1203 LGBTQI Juveniles, Section III (A) (p. 1) prohibits discrimination and physical and sexual harassment or assault based on race, national origin, color, creed, religion, physical or mental disability, sex, political beliefs, and actual or perceived sexual orientation or gender identity. Section III (I) (p. 6) states, "Consistent with their rights, juveniles will not be physically searched in a manner that is humiliating or degrading."

The auditor interviewed 12 randomly selected staff from all three shifts. One of the staff had been hired within the past two weeks and was pending the completion of the training and reported being at the facility under constant supervision by a supervisor and currently participating in on-the-job training. With the exception of the newly hired staff, the remaining 11 staff reported they are prohibited from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. At the time of the audit, the agency reported there were no transgender or intersex residents currently being housed at the facility. The auditor requested that if a transgender or intersex resident was admitted during the onsite audit phase, that facility staff advise of the admission. The auditor randomly asked staff if they were aware of any transgender or intersex residents were currently placed at the facility, to which they responded no.

**115.315(f).**

In the PAQ, the agency reported 100% of the security staff are in how to conduct cross-gender pat down searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs. A review of the training records reflected security staff participated in the "PREA Cross Gender PAT Searches" and the course description states, "Training included how to conduct PAT searches on cross gender and transgender individuals."

The auditor interviewed 12 randomly selected staff from all three shifts. One of the staff had been hired within the past two weeks and was pending the completion of the training and reported being at the facility under constant supervision by a supervisor and currently participating in on-the-job training. With the exception of the newly hired staff, the remaining staff reported the following: they have been trained just in case; have been trained but it is not allowed; there are always enough staff; and would only search same gender residents.

**Corrective Action:**

1. The auditor recommends no corrective action.

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

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

**115.316 (a)**

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing?  Yes  No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision?  Yes  No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities?  Yes  No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities?  Yes  No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities?  Yes  No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.)  Yes  No
- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing?  Yes  No
- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?  Yes  No

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

#### 115.316 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient?  Yes  No
- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?  Yes  No

#### 115.316 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations?  Yes  No

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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

**The following evidence was analyzed in making the compliance determination:**

1. Documents:

- a. Pre-Audit Questionnaire (PAQ)
- b. Memo – 115.316 (*dated 8/30/18*)
- c. AS-902 Preventing and Detecting Sexual Abuse and Sexual Harassment (*revised 6/12/17*)
- d. RS-1.35 Housing Classification Plan (*revised 3/9/18*)
- e. RS-2.50 First Responder Duties (*revised 6/12/17*)
- f. AS-903 First Responder Duties (*revised 6/12/17*)
- g. Resident Informational and Education Materials
  - i. Departamento de Libertad Vigilada del Condado de Travis Servicios Residenciales Manual para Residentes (Spanish version of the TCJPD Residential Services Resident Manual)
  - ii. PREA Posters (English and Spanish)
  - iii. PREA Brochure (English and Spanish)

2. Interviews:

- a. Agency Head
- b. Residents with Disabilities or who are Limited English Proficient
- c. Random Sample of Staff

3. Onsite Review:

- a. Housing Units, Classrooms, Common Areas, Corridors, and Visitation

**Findings (By Provision):**

**115.316(a).**

In the PAQ, the agency reported it has established procedures to provide disabled residents equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

Agency Policy AS-902 Preventing and Detecting Sexual Abuse and Sexual Harassment, Section III (D.8, F) (p. 3, p. 5) addresses special programming for target population needs and the needs of each resident will be reviewed to ensure appropriate housing, programming, education and potential work assignments are made. Section III (G.2) (p. 5-6) addresses appropriate steps that will be taken to ensure residents with disabilities are addressed. The policy addresses using terminology appropriate to the residents' age, sophistication, and intelligence; physical or intellectual disabilities; and limited reading skills or literacy issues. Agency Policy RS-1.35 Housing Classification Plan, Section III (I) (p. 6) states, "Time out rooms meet the Americans with Disabilities Act (ADA) requirements for the housing of disabled juveniles. Juveniles with disabilities will be provided the following: 1. Housing that provides for their safety and security; and 2. Rooms or housing units designed to provide for integration with other residents." The agency memo reflects interpreters are available for those that are deaf or hard of hearing. If the juvenile attends an Austin Independent School District (AISD) campus when not in a facility, AISD is responsible for providing interpreters during school hours. Services for the Deaf and Hard of Hearing provide interpreters for non-AISD students and during typical program hours. The agency provided the following website for additional information: <https://www.traviscountytx.gov/health-human-services/deaf-hard-of-hearing>. A review of the website reflects a range of services available to include legal services and interpreting services.

Staff interviewed reported the agency has established procedures to provide residents with disabilities and residents who are limited English proficient equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Staff reported when a resident is identified with a special need, they bring in the resource or seek it. They also work with the families. Staff reported bilingual staff have conversation and interviewing skills, documents are translated, including posted documents. At the time of the audit, the agency reported there were no residents with disabilities or who are limited English proficient currently being housed at the facility. The auditor requested that if a resident with a disability or who was limited English proficient was admitted during the onsite audit phase, that facility staff advise the auditor of the admission. The auditor randomly asked staff if they were aware of any residents with disabilities or who are limited English proficient that were currently placed at the facility, to which they responded no.

During the onsite review, the auditor noted the PREA posters are in English and Spanish and are posted in each housing unit, classrooms, common areas, corridors, and visitation. The auditor noted that the vocational classroom did not have the PREA posters and requested staff also post the PREA information in the classroom.

**115.316(b).**

In the PAQ, the agency reported it has established procedures to provide residents with limited English proficiency the equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

Agency Policy AS-902 Preventing and Detecting Sexual Abuse and Sexual Harassment, Section III (G.2.d) (p. 6) addresses providing interpreters as needed. The agency memo reflects bilingual staff are available for translation services as needed for those that are limited English proficient. The Spanish resident handbook and PREA materials address the residents' rights to be free of sexual abuse and sexual harassment.

At the time of the audit, the agency reported there were no residents who are limited English proficient currently being housed at the facility. The auditor requested that if a resident who was limited English proficient was admitted during the onsite audit phase, that facility staff advise the auditor of the admission. The auditor randomly asked staff if they were aware of any residents who are limited English proficient that were currently placed at the facility, to which they responded no.

**115.316(c).**

In the PAQ, the agency reported agency policy prohibits the use of resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations. The agency also reported it would document circumstances in which resident interpreters, resident readers, or other types of resident assistants are used. The agency reported there have been no instances where resident interpreters, resident readers, or other types of resident assistants have been used in the past 12 months.

Agency Policy RS-2.50 First Responder Duties, Section III (C.1.b) (p. 5) addresses the prohibition of using resident to interpret, read, or otherwise assist except in limited circumstances. Agency Policy AS-903 First Responder Duties, Section III (C.1.c, and D.2.c) (p. 5) requires staff to document when juvenile interpreters are used. Agency Policy RS-2.50 First Responder Duties, Section III (C.1.c) (p. 5) requires staff document if a juvenile interpreter is used.

The auditor interviewed 12 randomly selected staff from all three shifts. One of the staff had been hired within the past two weeks and was pending the completion of the training and reported being at the facility under constant supervision by a supervisor and currently participating in on-the-job training. With the exception of the newly hired staff, the remaining 11 staff reported the use of resident interpreters would not be allowed. Staff reported there are enough bilingual staff, and two staff added that bilingual therapists have been observed working with the parents of residents that do not speak English. At the time of the audit, the agency reported there were no residents who are limited English proficient currently being housed at the facility. The auditor requested that if a resident who was limited English proficient was admitted during the onsite audit phase, that facility staff advise the auditor of the admission. The auditor randomly asked staff if they were aware of any residents who are limited English proficient that were currently placed at the facility, to which they responded no.

**Corrective Action:**

1. The auditor recommends no corrective action.

## Standard 115.317: Hiring and promotion decisions

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

#### 115.317 (a)

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

#### 115.317 (b)

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

#### 115.317 (c)

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

#### 115.317 (d)

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

#### 115.317 (e)

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

#### 115.317 (f)

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

- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct?  Yes  No

#### 115.317 (g)

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

#### 115.317 (h)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

### The following evidence was analyzed in making the compliance determination:

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
  - b. AS-203 Personnel Selection, Retention and Promotion (*revised 12/1/16*)
  - c. AS-209 Code of Ethics Staff – Juvenile Relationships (*revised 2/6/15*)
  - d. *TCJPD Affirmative Duty to Disclose* Form (*revised 11/2/15*)
  - e. *Regular Hiring / Recommendation Checklist* (*revised 10/2017*)
  - f. Austin Community College (ACC) District Continuing Education Department Vocational Training and Development Agreement (*signed 5-25-17*)
  - g. Employee and Contractor Files
2. Interviews:
  - a. Administrative (Human Resources) Staff

## Findings (By Provision):

### 115.317(a).

In the PAQ, the agency reported it has agency policy that prohibit hiring or promoting anyone who may have contact with residents or enlisting the services of any contractor who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution; has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above.

Agency Policy AS-203 Personnel Selection, Retention and Promotion, Section II (p. 1) defines staff as any person hired to a position in the department and, for the purposes of this policy, includes interns, volunteer or contracted program services staff. Section III (F.3.f-i) (pp. 3-4) addresses all three elements of this provision as well as any individual required to register as a sex offender in accordance with the Texas Code of Criminal Procedure. Agency Policy AS-209 Code of Ethics Staff – Juvenile Relationships, Section I (B.7) (p. 2) includes a requirement that juvenile justice professionals must not be designated as a perpetrator in an abuse, exploitation, and neglect investigation conducted by TJJD under the Texas Family Code Chapter 261.

The agency requires all job applicants and contract staff to complete and sign the *TCJPD Affirmative Duty to Disclose Form*, which contains the three required questions, during the application process. All staff, including contract staff, are required to sign a new form on or about the month of January on an annual basis. A review of 23 employee files, which included five employees hired within the past 12 months, and two contract staff files reflected all contained the required completed and signed Affirmative Duty to Disclose Forms.

### 115.317(b).

In the PAQ, the agency reported agency policy requires it consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents. Agency Policy AS-203 Personnel Selection, Retention and Promotion, Section III (F.6) (p. 4) requires the department consider any incidents of sexual harassment in determining whether to hire, promote or enlist the services of any contractor or staff. Staff interviewed reported the facility considers prior incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor.

The agency requires all job applicants and contract staff to complete and sign the *TCJPD Affirmative Duty to Disclose Form*, which contains the three required questions, during the application process. All staff, including contract staff, are required to sign a new form on or about the month of January on an annual basis. A review of 23 employee files, which included five employees hired within the past 12 months, and two contract staff files reflected all contained the required completed and signed Affirmative Duty to Disclose Forms. The form includes “material omissions” and “provision of materially false information” clauses, which allows for the disciplinary action up to an including termination. The application also inquires on whether the applicant has ever been the subject of an investigation and/or an alleged perpetrator in a sexual abuse and/or sexual harassment investigation.

### 115.317(c).

In the PAQ, the agency reported before hiring new employees, who may have contact with residents, the agency: performs a criminal background records check, consults any child abuse registry maintained by the State or locality in which the employee would work, and makes its best efforts to

contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. The agency reported it has hired 89 staff who have had a criminal background check in the past 12 months.

Agency Policy AS-203 Personnel Selection, Retention and Promotion, Section III (F.5, 7) (p. 4) requires the department will make its best efforts to contact all prior institutional employers and that criminal history and child abuse registry checks will be conducted every two years for certified officers and at least every five years for non-certified staff, contractors, interns and volunteers. Staff interviewed reported the agency conducts criminal record background checks prior to the new employee's effective date of hire and for promotions. Staff reported the agency also consults the child abuse registry before hiring new employees.

A review of 23 employee files, which included five employees hired within the past 12 months, reflected the appropriate criminal background records and child abuse registry checks had been conducted. Two of the 23 employee files reviewed reflected staff who had worked at a prior institution. The files reflected a reference check was conducted on both employees.

**115.317(d).**

In the PAQ, the agency reported it performs a criminal background records check and consults with applicable child abuse registries before enlisting the services of any contractor who may have contact with residents. The agency also reported there were no contracts for services where criminal background record checks were conducted on all staff covered in the contract who might have contact with residents in the past 12 months.

Agency Policy AS-203 Personnel Selection, Retention and Promotion, Section II (p. 1) defines staff as any person hired to a position in the department and, for the purposed of this policy, includes interns, volunteer or contracted program services staff. Agency Policy AS-203 Personnel Selection, Retention and Promotion, Section III (F.5, 7) (p. 4) requires the department will make its best efforts to contact all prior institutional employers and that criminal history and child abuse registry checks will be conducted every two years for certified officers and at least every five years for non-certified staff, contractors, interns and volunteers.

Staff interviewed reported the contract agencies conduct the criminal record background checks and the agency conducts the history checks prior to hiring the contractor. Staff reported the agency also consults the child abuse registry before hiring new contractors.

A review of the two contract staff files reflected one completed criminal background check. The second file reflected documentation that the contract entity, Austin Community College (ACC,) had conducted the criminal background check, per contractual agreement and cleared the contract staff. The contract included an attachment (ACC 227502; dated 11/21/18; Update 35) Section "Participation in the Criminal History Clearinghouse." Per 37 TAC 27.171, .172(4), (8), .174, ACC is authorized to be provided with the Texas and FBI fingerprint-based criminal history results and with subscription and notification service to disseminate updated criminal history information. This allows ACC to conduct the background check on the contract staff assigned to the facility and provide the facility with verification that the contract staff has cleared the criminal background check. The contract attachment further states, "Entities shall maintain compliance with the FBI Criminal Justice Information Services Security Policy. Entities shall allow DPSS and FBI to conduct audits of their clearinghouse accounts to prevent any unauthorized access, use, or dissemination of the information. The auditor noted, in the instance where one of the ACC contract staff's criminal background clearance record was included in the file, the agency reported, when the community liaison does not receive the letter in a timely manner, he has the

candidate go and get them completed before employment at the TCJPD.” Both contractor files reflected the appropriate child abuse registry checks had been conducted.

**115.317(e).**

In the PAQ, the agency reported it conducts criminal background records checks at least every five years of current employees and contractors who may have contact with residents or has in place a system for otherwise capturing such information for current employees.

Agency Policy AS-203 Personnel Selection, Retention and Promotion, Section II (p. 1) defines staff as any person hired to a position in the department and, for the purposes of this policy, includes interns, volunteer or contracted program services staff. Agency Policy AS-203 Personnel Selection, Retention and Promotion, Section III (F.7) (p. 4) requires the department conduct criminal history and child abuse registry checks every two years for certified officers and at least every five years for non-certified staff, contractors, interns and volunteers.

Staff interviewed reported the agency utilizes the “FACT Clearinghouse,” which is also known as the FAST system and is operated by the Texas Department of Public Safety (DPS). The system maintains a database of all fingerprinted employees and is designed to automatically alert an employer, if an employee is arrested.

A review of the 23 employee files included 13 employees that had been employed at the facility for more than five years. One file reflected the five-year criminal background check was not conducted. The agency took immediate corrective action and initiated the criminal background check while the auditor was still onsite. Supporting documentation reflected clearance checks for the State and FBI checks were completed and received on the last day of the onsite audit.

**115.317(f).**

Staff interviewed reported the agency asks all applicants and employees about previous misconduct in written applications for hiring. Applicants are also asked to self-disclose in supplemental questions and during the interviews, plus respond and sign the Affirmative Duty to Disclose Form. Current employees are asked to respond and sign the Affirmative Duty to Disclose Form each year during the month of January, but no later than February.

The agency requires all job applicants and contract staff to complete and sign the *TCJPD Affirmative Duty to Disclose Form*, which contains the three required questions, during the application process. All staff, including contract staff, are required to sign a new form on or about the month of January on an annual basis. A review of 23 employee files, which included five employees hired within the past 12 months, and two contract staff files reflected all contained the required completed and signed Affirmative Duty to Disclose Forms.

**115.317(g).**

In the PAQ, the agency reported it considers material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

Agency Policy AS-203 Personnel Selection, Retention and Promotion, Section III (F.1) (p. 3) directs the department to ask prospective employees directly about any previous sexual harassment allegations and misconduct during the application process and states, “Material omissions regarding misconduct or providing false information will be grounds for termination.” Agency Policy AS-209 Code of Ethics Staff – Juvenile Relationships, Section I (B.11) (p. 3) includes a requirement that juvenile justice professionals must not falsify or make material omissions to governmental records.

A review of 23 employee files, which included five employees hired within the past 12 months, and two contract staff files reflected all contained the required completed and signed Affirmative Duty to Disclose Forms. The form includes “material omissions” and “provision of materially false information” clauses, which allows for the disciplinary action up to an including termination.

**115.317(h).**

Agency Policy AS-203 Personnel Selection, Retention and Promotion, Section III (F.7.c) (p. 4) states, “The Department will provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer to whom he or she has applied.

Staff interviewed reported the agency provides information on substantiated allegations of sexual abuse or sexual harassment involving former employees upon receiving a request from an institution the former employee applies for work at.

**Corrective Action:**

1. The auditor recommended no corrective action.

**Standard 115.318: Upgrades to facilities and technologies**

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

**115.318 (a)**

- If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency’s ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.)  
 Yes  No  NA

**115.318 (b)**

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

**Auditor Overall Compliance Determination**

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

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

### Instructions for Overall Compliance Determination Narrative

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

### The following evidence was analyzed in making the compliance determination:

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
2. Interviews:
  - a. Agency Head
  - b. Superintendent
3. Onsite Review:
  - a. Housing Units

### Findings (By Provision):

#### **115.318(a).**

In the PAQ, the agency reported it has not designed or acquired any new facility or planned any substantial expansion or modification of existing facilities.

Staff interviewed reported the agency has not had any substantial expansion or modification to the facility since 2012, but is currently working on the new camera surveillance project, which was getting installed while the auditor was onsite. Staff reported the agency considers the effects of substantial modifications on its ability to protect residents from sexual abuse from the start. Any planning, such as the Master Plan for future expansion, considers the following facility issues: security and environment, PREA, staff supervision, transportation, medical, housing, hygiene, classrooms, activity rooms, gym, and the library. Time is spent talking with staff, including staff that are with residents on a day-to-day basis, treatment staff and facility operations staff. The auditor noted there was no new expansion or modification of existing facilities during the onsite review.

#### **115.318(b).**

In the PAQ, the agency reported it has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology. Currently, the agency is working on the installation of a video surveillance system. The project installation is broken into six different phases, starting with the Detention Services Building, which is designated as Phase 1. The ISC and Shelter will be the last phases of the installation process.

Staff interviewed reported the agency is currently working on the new camera surveillance project, which will add over 200 cameras to track staff/resident movement throughout the building. In planning for the new camera system, a committee worked with subject matter experts, as well as with fiscal and research staff and considered the resident's safety, security, and well-being, and staff safety. The committee also worked with general housekeeping staff in the planning process. Staff reported agency staff have researched and reviewed available technology and considered how to use it, and how to maintain and support it. While onsite, the auditor observed the initiation of the installation process of the camera system in the vacant housing units.

**Corrective Action:**

1. The auditor recommends no corrective action.

## RESPONSIVE PLANNING

### Standard 115.321: Evidence protocol and forensic medical examinations

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

#### 115.321 (a)

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

#### 115.321 (b)

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

#### 115.321 (c)

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

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

#### 115.321 (d)

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

#### 115.321 (e)

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

#### 115.321 (f)

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

#### 115.321 (g)

- Auditor is not required to audit this provision.

#### 115.321 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.321(d) above.)  Yes  No  NA

## Auditor Overall Compliance Determination

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

## Instructions for Overall Compliance Determination Narrative

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

### The following evidence was analyzed in making the compliance determination:

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
  - b. Law Enforcement Request for Sexual Abuse Allegations Protocols Email (*dated 4-16-16*)
  - c. AS-217 B Conducting Administrative Investigations (*revised 12/1/16*)
  - d. AS-904 Corrective Action and Notifications (*revised 12/1/16*)
  - e. AS-901 Reporting of Child Abuse, Neglect, and Exploitation (*revised 12/1/16*)
  - f. Verification of Uniform Evidence Protocol Email (*dated 3/16/16*)
  - g. AS-905 Services for Victims of Sexual Abuse (*revised 2/19/16*)
  - h. SafePlace 2014 Award Letter (*dated 9/22/14*)
  - i. SafePlace, Inc. Certified Sexual Assault Training Program Certification, Certificate Number #14-0922-01-16 (*awarded 9/22/14 through 9/21/16*)
  - j. Sexual Assault Training Program (SATP) Certification Guide Final TAASA Approved 09-2014
  - k. Memorandum of Understanding (MOU) with SafePlace (*dated 9/8/14*)
  - l. Sexual Assault Check List
2. Interviews:
  - a. Random Sample of Staff
  - b. SAFE/SANE Staff
  - c. PREA Compliance Manager
  - d. Residents who Reported a Sexual Abuse

### Findings (By Provision):

#### 115.321(a).

In the PAQ, the agency reported it is responsible for conducting administrative investigations and the Travis County Sheriff's Office is responsible for conducting criminal investigations.

Agency Policy AS-904 Corrective Action and Notifications, Section I (B) (p. 2), states, "The Department will ensure that all allegations of sexual abuse and sexual harassment are investigated." The policy also

requires the department to investigate allegations in accordance with Agency AS-217 B. Agency Policies AS-217 Administrative Investigations and AS-217 B Conducting Administrative Investigations, Sections I (p. 1) states, "The Department conducts administrative investigations of alleged violations of Department policy, procedure, contract or standard." Agency Policy AS-901 Reporting of Child Abuse, Neglect, and Exploitation, Section III (C.1) (p. 5) instructs staff to notify the law enforcement agency having criminal investigation jurisdiction of the allegations, which includes TCSO, Austin Police Department and/or AISD Police Department or satellite office.

Agency Policy AS-217 B Conducting Administrative Investigations, Section III (D.2) (p. 2), outlines evidence collection procedures - Sexual Assault Check List. The Law Enforcement Request for Sexual Abuse Allegations Protocols Email (dated 4-16-16) reflects the communication between the TCSO and the agency refers to the attached TCSO's sexual assault protocols.

The auditor interviewed 12 randomly selected staff from all three shifts. One of the staff had been hired within the past two weeks and was pending the completion of the training and reported being at the facility under constant supervision by a supervisor and currently participating in on-the-job training. With the exception of the newly hired staff, six of the remaining 11 staff stated they would secure the scene and provide instructions to the residents in order to preserve any evidence. All indicated they would immediately alert their supervisor, with others indicating they would also contact the agency's PREA Compliance Department (PREA Staff), medical, management, CJPO, TJJD, hotline, and/or TCSO.

**115.321(b).**

In the PAQ, the agency reported the protocol is developmentally appropriate for youth, and was adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011.

Agency Policy AS-905 Services for Victims of Sexual Abuse, Section III (B.3.b) (p. 3) states, "The forensic protocol will be developmentally appropriate for youth and to the extent possible, be based on the protocol for sexual assault medical forensic examinations."

The Verification of Uniform Evidence Protocol Email (dated 3/16/16) between the agency, SANE staff and the TCSO, indicates the SafePlace SANE nurses follow the "International Association of Forensic Nurses' Standards of Care for Sexual Assault Nurse Examiners, Scope of Practice for Sexual Assault Nurse Examiners and on the US Department of Justice's A National Protocol for Sexual Assault Medical Forensic Examinations, 2013."

SANE/SAFE staff interviewed reported they use the following references to build their protocols:

1. International Association of Forensic Nurses: Standards of Care for Sexual Assault Nurse Examiners, Scope of Practice for Sexual Assault Nurse Examiners;
2. US Department of Justice: A National Protocol for Sexual Assault Medical Forensic Examinations, Adult/Adolescent, 2013;
3. US Department of Justice: A National Protocol for Sexual Assault Medical Forensic Examinations, Pediatric, 2016;
4. Texas Family Code Sections 32.001, 32.003, and 32.005;
5. Consultation with:
  - a. A named Doctor, Assistant Professor, and Director of Psychiatric Mental Health Nurse Practitioner Graduate Program at the University of Texas at Austin School of Nursing;

b. A second named Doctor.

**115.321(c).**

In the PAQ, the agency reported it offers all residents who experience sexual abuse access to forensic medical examinations, at an outside facility, without financial cost, where evidentiarily or medically appropriate. The agency reported Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) perform the examinations, and where SANEs or SAFEs are not available, a qualified medical practitioner performs the forensic medical examination. The agency provided a copy of the Memorandum of Understanding (MOU) between the agency and SafePlace – Travis County Domestic Violence and Sexual Assault Survival Center.

Agency Policy AS-905 Services for Victims of Sexual Abuse, Section III (B.2 and 3.a) (p. 2) states that the cost of the treatment services will not be assessed to the victim or his/her family and the department will transport the juvenile victims of sexual abuse to a hospital, clinic, or emergency room that can provide a forensic examination. The policy also states, "As available, the forensic exam will be provided by Sexual Assault Nurse Examiner (SANE) or Sexual Assault Forensic Examiner (SAFE) or other qualified medical practitioner."

The SafePlace 2014 Award Letter is dated 9/22/14 and indicates the certification is valid for two years: from September 22, 2014 through September 21, 2016. The corresponding Office of the Attorney General (OAG) Sexual Assault Training Program (SATP) Certification Guide is dated February 28, 2014.

The MOU between the agency and SafePlace is dated 9/4/14 and reflects the MOU will remain in effect until either party terminates the MOU with a 60-day written notice sent to the other party. The MOU outlines each party's responsibilities. The Verification of Uniform Evidence Protocol Email (*dated 3/16/16*) between the agency, SANE staff and the TCSO states, "If an individual in custody makes an outcry of sexual abuse, the individual is transported to a hospital where the SANE nurses would perform a forensic examination – St. David's emergency departments. If the individual is under 18, Dell Children's Hospital would provide the SANE exam."

SAFE/SANE staff interviewed reported SAFE/SANE nurses are always available and responsible for conducting all forensic medical exams. Staff reported SafeAlliance and SafePlace were merged on 1/1/17. Staff reported their nurses certify with the Texas Office of the Attorney General, The International Association of Forensic Nurses, or both. Staff also reported the certification records are maintained by their human resources department.

**115.321(d).**

In the PAQ, the agency reported it attempted and documented its efforts to make available to the victim a victim advocate from a rape crisis center. The agency also reported if a rape crisis center is not available to provide victim advocate services, it provides a qualified staff member from a community-based organization, or a qualified agency staff member to provide these services.

The MOU between the agency and SafePlace is dated 9/4/14 and reflects the MOU will remain in effect until either party terminates the MOU with a 60-day written notice sent to the other party. The MOU outlines in Section II (k) (p. 3) that SafePlace will provide a victim advocate upon request from TCJPD or a juvenile.

Agency Policy AS-905 Services for Victims of Sexual Abuse, Section III (C.2) (p. 3) states, “The mental health professional will make the determination of appropriate counseling referrals, to include crisis intervention services, follow-up services, treatment plans and referrals for continued care.”

Staff interviewed reported residents are informed during orientation and SafeAlliance information is posted. Staff added that the Ombudsman will also visit with the resident. A resident who reported a sexual abuse incident was interviewed. The incident did not rise to the level requiring a forensic exam. The resident reported his parents were immediately contacted, and he spoke with his mother. The resident also reported TJJD investigated the case. The resident reported the facility offered services, but no other services were requested.

**115.321(e).**

In the PAQ, the agency reported, if requested by the victim, a victim advocate, qualified agency staff member, or qualified community-based organization staff member accompanies and supports the victim through the forensic medical examination process and investigatory interviews

Agency Policy AS-905 Services for Victims of Sexual Abuse, Section III (E.1) (p. 3) states, “If requested by the juvenile, a victim advocate or qualified individual from a community-based organization will accompany and support the juvenile through the forensic medical examination and investigatory interviews.”

Staff interviewed reported the agency has an MOU with SafeAlliance. They will accompany the resident and will respond and assist as well as advocate for the resident. A resident who reported a sexual abuse incident was interviewed. The incident did not rise to the level requiring a forensic exam. The resident reported the facility offered services, but no other services were requested.

**115.321(f).**

In the PAQ, the agency reported it requested the agency responsible for investigating criminal allegations, to follow the requirements of 115.321 (a-e).

The Law Enforcement Request for Sexual Abuse Allegations Protocols Email (*dated 4-16-16*) reflects communication between the agency and TCSO and indicates the agency requesting TCSO to “follow the protocols in the PREA standards (115.321) for investigations.” The agency utilizes the Sexual Assault Check List, which outlines the following: initial response, upon arrival, evidence collection at the scene, transportation (if not transported by EMS), and upon arrival at the hospital.

**115.321(g).**

Auditor is not required to audit this provision.

**115.321(h).**

Agency Policy AS-905 Services for Victims of Sexual Abuse, Section III (C.2) (p. 3) states, “The mental health professional will make the determination of appropriate counseling referrals, to include crisis intervention services, follow-up services, treatment plans and referrals for continued care.”

**Corrective Action:**

1. The auditor recommends no corrective action.

## Standard 115.322: Policies to ensure referrals of allegations for investigations

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

#### 115.322 (a)

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

#### 115.322 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior?  Yes  No
- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means?  Yes  No
- Does the agency document all such referrals?  Yes  No

#### 115.322 (c)

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

#### 115.322 (d)

- Auditor is not required to audit this provision.

#### 115.322 (e)

- Auditor is not required to audit this provision.

### Auditor Overall Compliance Determination

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

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

### Instructions for Overall Compliance Determination Narrative

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

### The following evidence was analyzed in making the compliance determination:

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
  - b. AS-217 B Conducting Administrative Investigations (*revised 12/1/16*)
  - c. AS-901 Reporting of Child Abuse, Neglect, and Exploitation (*revised 12/1/16*)
  - d. Memo – 115.371 (*dated 8/30/18*)
  
2. Interviews:
  - a. Agency Head
  - b. Investigative Staff

### Findings (By Provision):

#### **115.322(a).**

In the PAQ, the agency reported it ensures an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. The agency reported there were two allegations of sexual abuse and sexual harassment that were received in the past 12 months, and that both resulted in administrative and criminal investigations, which were completed.

Agency Policies AS-217 Administrative Investigations and AS-217 B Conducting Administrative Investigations, Sections I (p. 1) states, "The Department conducts administrative investigations of alleged violations of Department policy, procedure, contract or standard."

Agency staff interviewed reported the agency ensures an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. Staff reported investigations are handled sensitively. The director of the unit is involved right away, and the incident is reported to law enforcement, the Department of Family and Protective Services (DFPS) and TJJD. When an incident is reported, the resident is separated from the alleged perpetrator, whether it is another resident or staff. A medical exam would be conducted and services, such as mental health or otherwise, would be provided. Staff would secure the scene and law enforcement staff would assess and collect the evidence. A trained investigator would be assigned, and if the allegation involves staff, an investigator from the other unit would investigate. Documentation is done in a timely basis, follow-up is conducted, and the interviews are completed. The investigator prepares the report and a review of the findings is conducted. If the case is unfounded, it is still reviewed. If the case is founded, a review is conducted to determine what the agency can do better. The auditor interviewed the TCSO staff that are responsible for conducting criminal investigations. The TCSO staff reported they would be the entity that would file the charges. Staff reported there are two permanent positions assigned to the agency.

#### **115.322(b).**

In the PAQ, the agency reported it has a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. The agency reported the policy is published on the agency's website or made available to the public via other means.

Agency Policy AS-901 Reporting of Child Abuse, Neglect, and Exploitation, Section III (C.1) (p. 5) instructs staff to notify the law enforcement agency having criminal investigation jurisdiction of the allegations, which includes TCSO, Austin Police Department and/or AISD Police Department or satellite office. The agency's referral policy to the TCSO, including TJJD, is posted on the agency's website: [https://www.traviscountytx.gov/images/juvenile\\_court/Doc/referrals-policy.pdf](https://www.traviscountytx.gov/images/juvenile_court/Doc/referrals-policy.pdf) A review of both sexual abuse and sexual harassment allegations reflected TJJD was notified within 24 hours. In the Memo – 115.371, the agency reported both cases were referred to law enforcement and neither resulted in the filing of criminal charges. A review of the investigative files reflected no criminal charges were filed.

Agency staff interviewed reported allegations are referred to the TCSO for criminal investigation, unless the allegation does not involve potentially criminal behavior. The auditor interviewed the TCSO staff that are responsible for conducting criminal investigations. The TCSO staff reported they would be the entity that would file the charges. Staff reported there are two permanent positions assigned to the agency.

**115.322(c).**

Agency Policy AS-901 Reporting of Child Abuse, Neglect, and Exploitation, Section III (A.3) (p. 4), states, "The staff member will document pertinent information regarding the allegation on a Department serious incident report. Required notifications and / or due diligence efforts to notify appropriate individuals or agencies will be included in the report."

The agency's referral policy to the TCSO, including TJJD, is posted on the agency's website: [https://www.traviscountytx.gov/images/juvenile\\_court/Doc/referrals-policy.pdf](https://www.traviscountytx.gov/images/juvenile_court/Doc/referrals-policy.pdf)

**115.322(d).**

Auditor is not required to audit this provision

**115.322(e).**

Auditor is not required to audit this provision

**Corrective Action:**

1. The auditor recommended no corrective action.

## TRAINING AND EDUCATION

### Standard 115.331: Employee training

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

**115.331 (a)**

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

### 115.331 (b)

- Is such training tailored to the unique needs and attributes of residents of juvenile facilities?  Yes  No
- Is such training tailored to the gender of the residents at the employee's facility?  Yes  No
- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa?  Yes  No

### 115.331 (c)

- Have all current employees who may have contact with residents received such training?  
 Yes  No
- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures?  Yes  No
- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies?  Yes  No

### 115.331 (d)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

### The following evidence was analyzed in making the compliance determination:

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
  - b. AS-902 Preventing and Detecting Sexual Abuse and Sexual Harassment (*revised 6/12/17*)
  - c. AS-401 Staff Training and Development Plan (*revised 6/8/15*)
  - d. 2017-18 PREA Creating a Culture of Safety
  - e. TCJPD Training Acknowledge Form PREA Standard 115.331(a) (*revised 11-10-16*)
  - f. Training Records
2. Interviews:
  - a. Random Sample of Staff

## Findings (By Provision):

### 115.331(a).

In the PAQ, the agency reported it train all employees who may have contact with residents on all of the 11 topics required by PREA Standard 115.31.

AS-902 Preventing and Detecting Sexual Abuse and Sexual Harassment, Section III (C) (p. 3), states, "The staff will receive annual training on sexual abuse and sexual harassment as outlined in AS-401: Staff Training and Development Plan." Agency Policy AS-401 Staff Training and Development Plan, Section III (F.5) (pp. 10-11), lists as a requirement all 11 topics, plus adds the following topic: Certified officers shall be trained on conducting searches of transgender and intersex residents in a professional and respectful manner in the least intrusive manner possible that is consistent with security needs. Policy requires these topics be trained to staff during orientation and on an annual basis.

The 2017-18 PREA Creating a Culture of Safety PowerPoint Presentation outlines the following topics:

1. Zero-tolerance policy for sexual abuse and sexual harassment. (p. 60-62)
2. How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures. (pp. 63-65, 89-109, 116-124)
3. Residents' right to be free from sexual abuse and sexual harassment. (p. 61)
4. The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment. (p. 124)
5. The dynamics of sexual abuse and sexual harassment in juvenile facilities. (pp. 63-65, 89-95)
6. The common reactions of juvenile victims of sexual abuse and sexual harassment. (pp. 96-97)
7. How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents. (pp. 98-99, 103-106)
8. How to avoid inappropriate relationships with residents. (pp. 119-122)
9. How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents. (pp. 68-88, 121-122)
10. How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities. (pp. 107-108)
11. Relevant laws regarding the applicable age of consent. (p. 110)

Plus, the agency's added topic:

12. Certified officers shall be trained on conducting searches of transgender and intersex residents in a professional and respectful manner in the least intrusive manner possible that is consistent with security needs. Policy requires these topics be trained to staff during orientation and on an annual basis. Training documentation reflects the training is titled: *PREA Cross Gender PAT Searches Instructor Led Webinar*.

The auditor interviewed 12 randomly selected staff from all three shifts. One of the staff had just been hired within the past two weeks and was pending the completion of the training and reported being at the facility under constant supervision by a supervisor and currently participating in on-the-job training. With the exception of the newly hired staff, the remaining 11 staff reported being trained on an annual basis and would refer to the topics they could recall.

A review of 23 employee files, which included five employees hired within the past 12 months, reflected all staff had completed the required PREA training, including the five newly hired staff.

### 115.331(b).

In the PAQ, the agency reported the training tailored to the unique needs, attributes, and gender of residents. The agency also reported staff are not reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa and noted this element of this provision was not applicable. The auditor noted the second facility, which is a pre-adjudication (detention) facility, houses male and female residents. Additionally, only female staff are assigned to the shelter, which is designed to house only female residents.

**115.331(c).**

In the PAQ, the agency reported all current employees who may have contact with residents take mandatory training on an annual basis.

A review of 23 employee files, which included five employees hired within the past 12 months, reflected all staff had completed the required PREA Creating a Culture of Safety training on an annual basis.

**115.331(d).**

In the PAQ, the agency reported it documents, through employee signature, that employees understand the training they have received. Agency Policy AS-401 Staff Training and Development Plan, Section III (G) (p. 12) addresses training documentation, records and review. The "TCJPD Training Acknowledge Form PREA Standard 115.331(a)" form lists all of the 11 required topics. Upon completing the training, staff sign and date the form, which states, "I understand this training, the importance of these topics and the responsibilities for reporting any instance of sexual abuse or sexual harassment and reporting any retaliation for reporting."

A review of 23 employee files reflected all staff had signed the Training Acknowledgement Form, which states, "I understand this training, the importance of these topics and the responsibilities for reporting any instance of sexual abuse or sexual harassment and reporting any retaliation for reporting."

**Corrective Action:**

1. The auditor recommends no corrective action.

## Standard 115.332: Volunteer and contractor training

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

**115.332 (a)**

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

**115.332 (b)**

- Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)?  Yes  No

## 115.332 (c)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

### The following evidence was analyzed in making the compliance determination:

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
  - b. AS-1001 Citizen, Volunteer and Intern Services (*revised 6/8/15*)
  - c. AS-902 Preventing and Detecting Sexual Abuse and Sexual Harassment (*revised 6/12/17*)
  - d. TCJPD Volunteer/Intern Handbook 2015
  - e. TCJPD Volunteer/Intern Handbook 2018
  - f. Training Records
2. Interviews:
  - a. Volunteers and Contractors who have Contact with Residents

### Findings (By Provision):

#### 115.332(a).

In the PAQ, the agency reported all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures. The agency reported there are 25 volunteers and contractors who have been trained. The agency reported the policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response can be found on pages 34-41 of the intern/volunteer handbook.

Agency Policy AS-1001 Citizen, Volunteer and Intern Services, Section III (D.7, E) (*pp. 5-6*) addresses reporting requirements, required training topics, including identifying and reporting abuse, neglect, and exploitation, PREA and the department's policies and procedures on sexual abuse, prevention,

detection, and response (to include the department's zero tolerance policy towards sexual abuse). Agency Policy AS-902 Preventing and Detecting Sexual Abuse and Sexual Harassment, Section III (C) (p. 3), states, "Volunteers, Interns and Contractors will be trained as outlined in AS 1001: Citizen, Volunteer and Intern Services." A review of the Volunteer/Intern Handbook 2015 reflects the PREA, abuse, neglect and exploitation topics are addressed on pages 34-40. The Volunteer/Intern Handbook 2018 reflects that the PREA, abuse, neglect and exploitation topics are addressed on pages 29-36.

The auditor interviewed two volunteers and two contractors. Two reported they have been a contractor/volunteer since 2017; and two reported this was their first year as a contractor/volunteer. All reported they received PREA training twice. A review of three contractor and four volunteer training files reflected all had completed the required PREA training.

**115.332(b).**

In the PAQ, the agency reported all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents).

Agency Policy AS-1001 Citizen, Volunteer and Intern Services, Section III (D.7, E) (pp. 5-6) addresses reporting requirements, required training topics, including identifying and reporting abuse, neglect, and exploitation, PREA and the department's policies and procedures on sexual abuse, prevention, detection, and response (to include the department's zero tolerance policy towards sexual abuse).

The auditor interviewed two volunteers and two contractors. All recalled the importance of reporting and responding immediately/right away. The interviewees referred to the TCJPD procedures, a video training regarding detecting and the topics they were trained on. All reported they were aware of the reporting requirements and who to make the reports to.

**115.332(c).**

In the PAQ, the agency reported it maintains documentation confirming that volunteers and contractors understand the training they have received.

Agency Policy AS-1001 Citizen, Volunteer and Intern Services, Section III (A.7,8) (p. 2) requires the documentation of program activities, including maintaining required records, files, and database of volunteers. Policy also requires the Volunteer Coordinator to provide or make provisions for the orientation and ongoing training of organizations, volunteers and interns required by standards.

The auditor interviewed two volunteers and two contractors. All reported receiving the required training. One interviewee indicated the training is part of the "badging" process. A review of three contractor and four volunteer training files reflected all had signed the *Contractor Acknowledgement form*, which states, "I understand the contents of this training and understand the importance and responsibilities for compliance with the mandatory reporting laws."

**Corrective Action:**

1. The auditor recommends no corrective action.

**Standard 115.333: Resident education**

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

**115.333 (a)**

- During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment?  Yes  No
- During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment?  Yes  No
- Is this information presented in an age-appropriate fashion?  Yes  No

**115.333 (b)**

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment?  Yes  No
- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents?  Yes  No
- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents?  Yes  No

**115.333 (c)**

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

**115.333 (d)**

- Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient?  Yes  No
- Does the agency provide resident education in formats accessible to all residents including those who: Are deaf?  Yes  No
- Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired?  Yes  No
- Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled?  Yes  No

- Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills?  Yes  No

#### 115.333 (e)

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

#### 115.333 (f)

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

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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

#### The following evidence was analyzed in making the compliance determination:

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
  - b. Memo – 115.333 (*dated 9/12/18*)
  - c. AS-902 Preventing and Detecting Sexual Abuse and Sexual Harassment (*revised 6/12/17*)
  - d. Resident Informational and Education Materials
    - i. TCJPD Residential Services Resident Handbook (*revised 1/9/19*)
    - ii. TCJPD Residential Services Orientation Packet Secure (*revised 8/29/17*)
    - iii. Departamento de Libertad Vigilada del Condado de Travis Servicios Residenciales Manual para Residentes (Spanish version of the TCJPD Residential Services Resident Manual)
    - iv. PREA Brochures (English and Spanish)
    - v. PREA Posters (English and Spanish)
    - vi. SafePlace Postings
  - e. Resident Files
    - i. Acknowledgement of Receipt of Orientation Information and Materials

ii. PREA: What You Need to Know; Resident Education

2. Interviews:

- a. Intake Staff
- b. Random Sample of Residents

3. Onsite Review:

- a. Housing Units, Classrooms, Common Areas – Dining (two) and Library, Corridors

**Findings (By Provision):**

**115.333(a).**

In the PAQ, the agency reported residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment, and information explaining how to report incidents or suspicions of sexual abuse or sexual harassment during intake. The agency also reported the information is presented in an age-appropriate fashion. The agency reported there were 31 residents admitted in the past 12 months that were given this information during intake.

Agency Policy AS-902 Preventing and Detecting Sexual Abuse and Sexual Harassment, Section III (G) (p. 5) states, "Residents in facilities will receive information on how to avoid risk situations, how to safely report sexual abuse and sexual harassment and their rights to be free of retaliation." Section III (G.3, 6) (pp. 6-7) outlines the following topics will be provided as part of orientation within 12 hours of intake: a. the Department's zero tolerance policy on any form of abuse; b. the right to be free from sexual abuse and sexual harassment; c. systems in place to protect them from harm to include accessing the grievance process, accessing outside parties and the court system and methods of contacting oversight agencies such as TJJD or DSHS; and d. being free from retaliation when utilizing the Department's methods of reporting complaints. Residents detained solely for civil immigration purposes will be provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security. AS-902 Preventing and Detecting Sexual Abuse and Sexual Harassment, Section III (G.4) (p. 3), states, "Education will be age-appropriate and provided in formats to ensure all residents may fully benefit from the Department's efforts to prevent, detect, and respond to sexual abuse and sexual harassment."

During the onsite review, the auditor requested the staff conduct a mock intake/screening with her, and staff demonstrated the process he would follow, which took over one hour. The mock intake took place in one of the vacant housing units, which is an area the staff indicated could be used. There is no formal "intake" area designated at the facility. The staff responsible for intake also conducts the initial screening. All resident files are secured in the unit coordinator's office within the housing unit the resident is assigned to. The Intake/Screening staff has a small office in the administrative section of the building, where he prepares the orientation packets.

Staff interviewed reported residents are provided information on the agency's zero-tolerance policy and how to report incidents or suspicions of sexual abuse and sexual harassment during the initial orientation process. Staff reported he meets with the resident prior to the actual intake as part of the informal process when the resident is transitioning/transferring from the pre-adjudication facility to the post-adjudication facility. This process allows him to introduce himself to the resident to reduce anxiety and review the process over what will occur during the actual orientation. Staff reported the resident gets this information informally and during the initial orientation.

Eleven (10 male; one female) residents were interviewed, with nine of the residents randomly selected. All but one of the residents reported receiving information about the facility's rules against sexual abuse and sexual harassment when they first arrived at the facility.

A review of 15 resident files reflected all residents were provided with the required PREA education information during intake. The files reflected the *Acknowledgment of Receipt of Orientation Information and Materials* forms were signed by the residents and staff. The signed forms included the time and date the forms were signed.

**115.333(b).**

In the PAQ, the agency reported it provides age-appropriate comprehensive education to residents either in person or through video regarding their rights to be free from sexual abuse and sexual harassment, their rights to be free from retaliation for reporting such incidents, and the agency policies and procedures for responding to such incidents within 10 days of intake to 31 residents.

Staff reported a test that outlines the orientation handbook is used. When reviewing the orientation handbook, residents are asked to initial each page and sign the Acknowledgement of Receipt of Orientation Information and Materials Form and the PREA Acknowledgement Form, which is the last document of the orientation handbook. Staff reported sometimes the residents ask for more time to review the information. Staff reported residents are made aware of their rights within one hour of intake.

The auditor noted the PREA Acknowledgement Form includes an acknowledgement that the resident viewed the PREA: What You Need to Know, a 16-minute close captioned resident education video. The orientation demonstration the staff did for the auditor did not include viewing the video. The Memo – 115.333 includes additional information on resident educational videos, which are a resource from the PREA Resource Center and graphic novels developed by the Washington College of Law End the Silence Program. The memo states, "Staff supplement the resources by reiterating the comprehensive education provided during the orientation process."

Eleven (10 male; one female) residents were interviewed, with nine of the residents randomly selected. Seven of the 11 residents reported receiving the information right away or on the first day. Two reported receiving the information two weeks after intake; one reported receiving the information one month after arriving; and a fourth reporting he received it two months after arriving but added he participated in the PREA session two weeks after arriving.

A review of 15 resident files reflected all residents were provided with the required PREA education information within 10 days. The files reflected the *PREA: What You Need to Know; Resident Education* forms were signed by the residents and staff. The signed forms include the time and date the forms were signed.

**115.333(c).**

When asked in the PAQ if any residents were not educated within 10 day if all residents were subsequently educated, the agency noted "N/A" as its response. The agency reported all residents have been educated and that policy required residents be educated as required by the standard.

Agency Policy AS-902 Preventing and Detecting Sexual Abuse and Sexual Harassment, Section III (G) (p. 5) states, "Residents in facilities will receive information on how to avoid risk situations, how to safely report sexual abuse and sexual harassment and their rights to be free of retaliation."

Staff interviewed noted that residents transitioning/transferring from the pre-adjudication facility to the post-adjudication facility are already familiar with PREA, and he affirms this by asking the resident if they have had any PREA groups while in the pre-adjudication facility, to which the resident responds yes. The pre-adjudication facility uses the PREA group process to provide the PREA comprehensive education information to the residents on a weekly basis. Staff reported he compares and reinforces the same message by referring to the PREA information posted in the pre-adjudication facility and demonstrating the same posters are in the post-adjudication facility. Staff uses the same concept when referring to the resident handbook and added that each housing unit has a resident handbook. Staff reported once in the unit, the resident reviews the handbook within two weeks.

A review of 15 resident files reflected all residents were provided with the required PREA education information within 10 days. The files reflected the *PREA: What You Need to Know; Resident Education* forms were signed by the residents and staff. The signed forms include the time and date the forms were signed.

**115.333(d).**

In the PAQ, the agency reported it provides resident education in formats accessible to all residents including those who are limited English proficient, are deaf, are visually impaired, are otherwise disabled, and have limited reading skills.

Memo – 115.333 refers to TJJJD standards for secure facilities, which require each resident receives a verbal orientation within 12 hours after admission into the facility, and that the agency provides the comprehensive, age-appropriate education to all residents during the orientation process. The memo also refers to and lists the resident education videos available through the PREA Resource Center. The videos are English and Spanish close-captioned.

AS-902 Preventing and Detecting Sexual Abuse and Sexual Harassment, Section III (G.4) (p. 3), states, “Education will be age-appropriate and provided in formats to ensure all residents may fully benefit from the Department’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment.”

The agency also utilizes the Departamento de Libertad Vigilada del Condado de Travis Servicios Residenciales Manual para Residentes (Spanish version of the TCJPD Residential Services Resident Manual) and the PREA Brochures (Spanish) as needed.

**115.333(e).**

In the PAQ, the agency reported it maintains documentation of resident participation in PREA education sessions.

A review of 15 resident files reflected the *Acknowledgment of Receipt of Orientation Information and Materials* and *PREA: What You Need to Know; Resident Education* forms were signed by the residents and staff. The signed forms include the time and date the forms were signed and are maintained in the resident’s files.

**115.333(f).**

In the PAQ, the agency reported it ensures that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats

Agency Policy AS-901 Reporting of Child Abuse, Neglect, and Exploitation, Section I (p. 1), and Section II (pp. 1-2) addresses the zero tolerance of sexual abuse and sexual harassment and the definitions of sexual abuse and sexual harassment.

During the onsite review, the auditor noted and verified the PREA posters were posted in the housing units, classrooms, common areas – dining (two) and library, and corridors. There were a few areas where both or one of the PREA posters were missing, which the facility staff immediately corrected the situation by posting new PREA posters. A copy of the Resident Handbook is maintained in each housing unit.

**Corrective Action:**

1. The auditor recommends no corrective action.

## Standard 115.334: Specialized training: Investigations

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

#### 115.334 (a)

- In addition to the general training provided to all employees pursuant to §115.331, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).]  Yes  No  NA

#### 115.334 (b)

- Does this specialized training include: Techniques for interviewing juvenile sexual abuse victims? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).]  Yes  No  NA
- Does this specialized training include: Proper use of Miranda and Garrity warnings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).]  Yes  No  NA
- Does this specialized training include: Sexual abuse evidence collection in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).]  Yes  No  NA
- Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).]  Yes  No  NA

#### 115.334 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? [N/A if the agency does

not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).]

Yes  No  NA

### 115.334 (d)

- Auditor is not required to audit this provision.

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

### The following evidence was analyzed in making the compliance determination:

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
  - b. Memo – 115.334 (*dated 8/1/18*)
  - c. AS-217 B Conducting Administrative Investigations (*revised 12/1/16*)
  - d. AS-401 Staff Training and Development Plan (*revised 6/8/15*)
  - e. Training Agenda: Investigating Sexual Misconduct: Training for Correctional Investigators, July 9-11, 2013
  - f. Faculty Bios, July 2013
  - g. PowerPoint Presentation Slides, (dated 2013)
    - i. Module 1 – Investigating Sexual Misconduct: Training for Correctional Investigators, (*dated 7/9-11/13*)
    - ii. Module 2 – Trauma and Victim Responses: Considerations for the Investigative Process (*dated 7/2/13*)
    - iii. Module 3 – First Response and Evidence Collection (*dated 7/2/13*)
    - iv. Module 5 – Prosecutorial Collaboration (*dated 7/2/13*)
    - v. Module 6 – The Forensic Exam (*not dated*)
    - vi. Module 7 – Agency Culture (*dated 7/2/13*)
    - vii. Module 8 – Tips for Interviewing Juveniles (*dated 7/2/13*)
    - viii. Module 9 – Legal Considerations (*dated 7/3/13*)
    - ix. Module 10 – Report Writing (*dated 7/2/13*)
    - x. Module 11 – PREA Audit Instrument: Intro to the Audit Instrument and Process (*dated 7/11/13*)

- h. Training Records, (dated July and August 2013)
- i. Training Records, (dated 8/28/13)
- j. Specialized Sexual Abuse Investigation Training Agenda (event date July 5-6, 2016)
- k. Revised Module and Topic List (provided to auditor 12-13-18)
  - i. Module 1: PREA Update and Standards Overview
  - ii. Module 2: Legal Issues and Liability
  - iii. Module 3: Culture
  - iv. Module 4: Trauma and Victim Response
  - v. Module 5: Medical and Mental Health Care
  - vi. Module 6: First Response and Evidence Collection
  - vii. Module 7: Adult Interviewing Techniques
  - viii. Module 7: Juvenile Interviewing Techniques
  - ix. Module 8: Report Writing
  - x. Module 9: Prosecutorial Collaboration
- l. Investigator's Training Records

2. Interviews:

- a. Investigative Staff

**Findings (By Provision):**

**115.334(a).**

In the PAQ, the agency reported agency policy requires investigators are trained in conducting sexual abuse investigations in confinement settings.

Agency Policy AS-217 B Conducting Administrative Investigations, Section III (C) (p. 2) requires designated investigators will receive specialized training on how to conduct sexual abuse and sexual harassment investigations in facilities/confinement settings.

Agency staff interviewed reported receiving the required training in May 2016, plus on-the-job training with his supervisor. Staff interviewed reported receiving training on the Garrity Warning. Staff reported no training was provided on the Miranda Warning, as they do not conduct criminal investigations. Staff reported also receiving training on the juvenile notice, and how to be sensitive towards sexual abuse and sexual harassment victims during the interviews. The auditor interviewed the TCSO staff that are responsible for conducting criminal investigations. The TCSO staff reported receiving the required PREA training through the Sheriff's Office and that PREA updates are provided via a monthly newsletter.

A review of three agency's investigator's staff training files, which were the staff that conducted the sexual abuse and sexual harassment investigation files reviewed, reflected all had received the required PREA basic training as well as the specialized training required of this provision.

**115.334(b).**

Agency Policy AS-217 B Conducting Administrative Investigations, Section III (B.2, and C) (p. 2) address all four required topics under this provision. The

Staff interviewed reported receiving training on all the required topics and added they do not collect the evidence. Staff reported if there is an active crime scene, they would preserve the scene and contact the TCSO. Staff would never wipe up body fluids. Staff also reported receiving training on the criteria and evidence required to substantiate a case.

A review of the investigator's staff training files reflected two staff had participated in the PREA: Investigating Sexual Abuse in a Confinement Setting presented by the National Institute of Corrections (NIC). The third staff member, who was no longer employed by the agency, had participated in the Investigating Sexual Misconduct, Training for Correctional Investigators, which was provided by the Moss Group.

**115.334(c).**

In the PAQ, the agency reported it maintains documentation demonstrating the investigators have completed the required training. The agency reported 10 investigators are currently employed who have completed the required training.

Agency Policy AS-401 Staff Training and Development Plan, Section III (G) (p. 12) addresses training documentation, records and review. The Memo – 115.333 lists the 10 investigators and outlines the dates they were trained. Supplemental information titled, TCJPD Investigation Team October 2018, provides an updated list of investigators designated as PREA Investigators. A revised list of the modules and titles was provided, as well as a copy of the Specialized Sexual Abuse Investigations Agenda conducted in Bryan, Texas, July 5-6, 2016.

A review of three agency's investigator's staff training files reflected the agency maintains documentation of staff participation in the required training.

**115.334(d).**

Auditor is not required to audit this provision.

**Corrective Action:**

1. The auditor recommends no corrective action.

## **Standard 115.335: Specialized training: Medical and mental health care**

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

### **115.335 (a)**

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

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

#### 115.335 (b)

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

#### 115.335 (c)

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

#### 115.335 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331?  Yes  No
- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.332?  Yes  No

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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

#### The following evidence was analyzed in making the compliance determination:

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
  - b. AS-401 Staff Training and Development Plan (*revised 6/8/15*)
  - c. Training Records

2. Interviews:
  - a. Medical and Mental Health Staff

**Findings (By Provision):**

**115.335(a).**

In the PAQ, the agency reported it has a policy related to the training of medical and mental health practitioners who work regularly in the facilities. The agency reported there are 16 medical and mental health care practitioners who work regularly at the facility and all 16 have received the required training.

Agency Policy AS-401 Staff Training and Development Plan, Section III (F.3.c.2) (p. 12) addresses specialized training for medical and mental health staff. Section III (F.3.c.2) (p. 12) addresses the required topics.

Staff interviewed reported receiving PREA training on an annual basis and that it is mandatory training. Staff reported topics include steps to take to notify, intake and the questions to ask the residents, reporting requirements – reporting to law enforcement and child protective services (CPS), referral to counselor. Staff reported they do not do anything regarding preserving evidence and have not been trained on this. A review of five medical and mental health staff training records reflected all staff had received the required PREA specialized training.

**115.335(b).**

In the PAQ, the agency reported its medical staff do not conduct forensic medical exams. Staff interviewed reported they do not conduct forensic exams and the facility is not equipped to conduct them.

**115.335(c).**

In the PAQ, the agency reported it maintains documentation demonstrating the medical and mental health practitioners have completed the required training. Agency Policy AS-401 Staff Training and Development Plan, Section III (G) (p. 12) addresses training documentation, records and review. A review of five medical and mental health staff training records reflected the agency maintains documentation staff have received the required PREA basic and specialized training.

**115.335(d).**

The agency reported all medical and mental health staff are employed by the agency. A review of five medical and mental health staff training records reflected the agency maintains documentation staff have received the required PREA basic and specialized training.

**Corrective Action:**

1. The auditor recommends no corrective action.

<b>SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS</b>
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**Standard 115.341: Screening for risk of victimization and abusiveness**

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

### 115.341 (a)

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

### 115.341 (b)

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

### 115.341 (c)

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Prior sexual victimization or abusiveness?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Current charges and offense history?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Age?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Level of emotional and cognitive development?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical size and stature?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Mental illness or mental disabilities?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Intellectual or developmental disabilities?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical disabilities?  Yes  No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: The resident's own perception of vulnerability?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents?  Yes  No

#### 115.341 (d)

- Is this information ascertained: Through conversations with the resident during the intake process and medical mental health screenings?  Yes  No
- Is this information ascertained: During classification assessments?  Yes  No
- Is this information ascertained: By reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files?  Yes  No

#### 115.341 (e)

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

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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

#### The following evidence was analyzed in making the compliance determination:

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
  - b. Memo – 115.334 (dated 9/13/18)

- c. AS-902 Preventing and Detecting Sexual Abuse and Sexual Harassment (*revised 6/12/17*)
- d. AS-905 Services for Victims of Sexual Abuse (*revised 2/19/16*)
- e. RS-1.35 Housing Classification Plan (*revised 3/9/18*)
- f. Residential Housing Screening (*revised 11/14/13*)
- g. Residential Housing Screener Review (*revised 9/24/13*)
- h. Intake/Admission Records Form
- i. ISC Residential Services Admission Packet
- j. Resident Files

2. Interviews:

- a. PREA Coordinator
- b. PREA Compliance Manager
- c. Staff Responsible for Risk Screening
- d. Residents

3. Onsite Review:

- a. Housing Units, Administrative Offices

**Findings (By Provision):**

**115.341(a).**

In the PAQ, the agency reported it has a policy that requires the screening for risk of sexual abuse victimization or sexual abusiveness toward other residents, upon admission or transfer from another facility. The agency reported the residents are screened within 72 hours. The agency reported 29 residents who entered the facility in the past 12 months who were screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their entry into the facility.

The Agency's Memo – 115.334, addresses the requirement that residents go through a housing screening process prior to being assigned a room and the orientation materials outline the methods of contacting nursing and counseling staff. The memo further states, "All residents entering into the ISC are required to have a psychological and / or a psychiatric evaluation within 365 days of admission. All residents in the ISC have a treatment and counseling staff assigned to their unit."

Agency Policy AS-905 Services for Victims of Sexual Abuse, Section III (A) (*pp. 1-2*) addresses the procedures for screening for prior sexual victimization or abusiveness. Agency Policy RS-1.35 Housing Classification Plan, Section II (B) (*p. 1*) defines the Housing Screener and its intended use. Section III (D) (*pp. 3-4*) requires the Treatment Team conduct the screening to determine housing and program placement within two hours and the factors that shall be considered during the screening process. Section III (D.5) (*p. 5*) requires the housing screener be reviewed periodically throughout a resident's stay at the facility, and that the review will be documented in the resident's file. Agency Policy AS-902 Preventing and Detecting Sexual Abuse and Sexual Harassment, Section III (G.3.c) (*p. 6*) addresses the systems in place during orientation to protect residents from harm, which includes accessing outside parties.

During the onsite review, the auditor requested the staff conduct a mock intake/screening with her, and staff demonstrated the process he would follow, which took over one hour. The mock intake took place in one of the vacant housing units, which is an area the staff indicated could be used. There is no formal "intake" area designated at the facility. The staff responsible for intake also conducts the initial screening. All resident files are secured in the unit coordinator's office within the housing unit the

resident is assigned to. The Intake/Screening staff has a small office in the administrative section of the building, where he prepares the orientation packets.

Staff interviewed reported two screenings are conducted: Health and Housing. Both are used for sexual abuse and neglect victimization and abusiveness and are conducted within the first hour of intake. Staff reported they use the Housing Screener and the initial screening tool is the entire packet and that the first step is key. The facility holds a Department Placement Staffing meeting prior to the initiation of placement and involves psychologists, case management staff, probation management staff, the probation officer assigned to the case and admissions (screening) staff. The case information and options are presented to the judge and the court decides on the placement. If the court orders placement, the following files are reviewed: probation officer's case file, psychological and medical history files, and caseworker's file. Staff reported they initiate the orientation packet process, at which point the resident is already aware of the placement. The screening staff meet with the resident and introduces the residential program to the resident and conducts a brief overview of the orientation packet. Staff reported the unit coordinator does the reassessment with the therapist and treatment team on a weekly or biweekly basis. During this meeting, the team discusses the resident's progress and the individual treatment plan. Staff reported there is constant reassessing and the unit coordinator is responsible for submitting addendums to the Housing Screener, which is used even when a resident is moved from one housing unit to another or from one cell to another. Staff added that if the resident goes back to detention (pre-adjudication facility) the whole process starts again.

Eleven (10 male; one female) residents were interviewed, with nine of the residents randomly selected. Two of the eleven residents had been in placement at the facility over 12 months. Of the nine residents interviewed, seven reported being asked the screening questions during orientation or on the same day.

A review of 15 resident files reflected all residents had the screening conducted on same date of admission utilizing the TCJPD Residential Housing Screening form. All files reviewed reflected subsequent reviews were conducted and documented on the TCJPD Residential Housing Screener Review forms.

**115.341(b).**

In the PAQ, the agency reported the risk assessment is conducted using an objective screening instrument – TCJPD Residential Housing Screening.

Agency Policy RS-1.35 Housing Classification Plan, Section III (D.3) (pp. 3-4) outlines the factors that shall be considered during the screening process, which are consistent with this provision of this standard. The facility uses the TCJPD Residential Housing Screening as the screening tool to be used by intake/screening staff.

**115.341(c).**

The TCJPD Residential Housing Screening Instrument addresses all the elements. The Intake/Admission Records form addresses the "Referring Complaint," and the ISC Residential Services Admission Packet Form includes the following documents, which are required prior to a juvenile's admission into an ISC-RS Program: Court Order indicating juvenile's commitment to ISC-Residential Services; Most Recent and Most Serious Offense Report; and Current Case History from Case Worker. Staff interviewed reported they use the Housing Screener, which is on page 22 of the orientation packet.

Initially, the auditor indicated in the interim report that she did not identify Element No. 3 – Current charge and offense history, and the auditor requested supplemental documentation verifying Item No. 3 is considered during screening. The agency responded by demonstrating compliance by highlighting the required element #3 in the *Travis County Juvenile Probation Department Residential Housing Screener*, a document previously provided to the auditor by the facility. As supplemental documentation, the facility also provided the *ISC Residential Services Admission Packet Form*, which lists the required documents required prior to the juvenile’s admission into an ISC-RS program. The list included the following documents: Court Order indicating juvenile’s commitment to ISC-Residential Services; Most Recent and Most Serious Offense Report; and the Current Case History from Case Worker.

**115.341(d).**

Staff interviewed reported they use the Housing Screener and the initial screening tool is the entire packet and that the first step is key. The facility holds a Department Placement Staffing meeting prior to the initiation of placement and involves psychologists, case management staff, probation management staff, the probation officer assigned to the case and admissions (screening) staff. The case information and options are presented to the judge and the court decides on the placement. If the court orders placement, the following files are reviewed: probation officer’s case file, psychological and medical history files, and caseworker’s file. Staff reported they initiate the orientation packet process, at which point the resident is already aware of the placement. The screening staff meet with the resident and introduces the residential program to the resident and conducts a brief overview of the orientation packet.

**115.341(e).**

Agency Policy AS-901 Reporting of Child Abuse, Neglect, and Exploitation, Section I (p. 1), and Section II (pp. 1-2) addresses the zero tolerance of sexual abuse and sexual harassment and the definitions of sexual abuse and sexual harassment.

Staff interviewed reported the therapist and unit coordinator have access to the files, which are secured in the unit coordinators’ offices in the units. Staff added that administrators have access to the files and that direct care staff get information from the unit coordinator in regards to the unit goals. Staff reported when treatment team meetings are conducted, everything is on the table and the resident and parents are invited to participate.

**Corrective Action:**

1. The auditor recommends no corrective action.

**Standard 115.342: Use of screening information**

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

**115.342 (a)**

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

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

#### 115.342 (b)

- Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged?  Yes  No
- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise?  Yes  No
- During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services?  Yes  No
- Do residents in isolation receive daily visits from a medical or mental health care clinician?  Yes  No
- Do residents also have access to other programs and work opportunities to the extent possible?  Yes  No

#### 115.342 (c)

- Does the agency always refrain from placing: Lesbian, gay, and bisexual residents in particular housing, bed, or other assignments solely on the basis of such identification or status?  Yes  No
- Does the agency always refrain from placing: Transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status?  Yes  No
- Does the agency always refrain from placing: Intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status?  Yes  No

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

#### 115.342 (d)

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

#### 115.342 (e)

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

#### 115.342 (f)

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

#### 115.342 (g)

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

#### 115.342 (h)

- If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A for h and i if facility doesn't use isolation?)  Yes  No  NA
- If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A for h and i if facility doesn't use isolation?)  Yes  No  NA

#### 115.342 (i)

- In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS?  Yes  No

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

### The following evidence was analyzed in making the compliance determination:

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
  - b. RS-1.35 Housing Classification Plan (*revised 3/9/18*)
  - c. RS-9.10 Discipline Plan (*revised 3/9/18*)
  - d. RS-9.40 Isolation, Seclusion and Separation (*effective 2/10/17*)
  - e. AS-1203 LGBTQI Juveniles (*revised 12/1/16*)
  - b. Residential Housing Screening (*revised 11/14/13*)
  - c. Residential Housing Screener Review (*revised 9/24/13*)
  - d. Resident Files
2. Interviews:
  - a. Superintendent
  - b. PREA Coordinator
  - c. PREA Compliance Manager
  - d. Staff Responsible for Risk Screening
  - e. Medical and Mental Health Staff
  - f. Staff who Supervise Residents in Isolation
  - g. Residents in Isolation (for risk of sexual victimization/who allege to have suffered sexual abuse)
  - h. Transgender/Intersex/Gay/Lesbian/Bisexual Residents
  - i. Transgender/Intersex Residents
  - j. File reviews
3. Onsite Review:
  - a. Housing Units, "Time Out" Rooms in Housing Units

## Findings (By Provision):

### 115.342(a).

In the PAQ, the agency reported it uses information from the risk screening tool to inform housing, bed, work, education, and program assignments with the goal of keeping all residents safe and free from sexual abuse.

Agency Policy RS-1.35 Housing Classification Plan, Section III (D) (*pp. 3-4*) requires the Treatment Team conduct the screening to determine housing and program placement within two hours and the factors that shall be considered during the screening process.

Staff interviewed reported if they have questions that are triggered during the assessment, they would have the Multidisciplinary Team (MDT) review the levels. The Unit Coordinator would also consider the information. Staff reported the unit coordinator does the reassessment with the therapist and treatment team on a weekly or biweekly basis. During this meeting, the team discusses the resident's progress and the individual treatment plan. Staff reported there is constant reassessing and the unit coordinator is responsible for submitting addendums to the Housing Screener, which is used even when a resident is moved from one housing unit to another or from one cell to another. Staff added that if the resident goes back to detention (pre-adjudication facility) the whole process starts again. Staff interviewed reported the therapist and unit coordinator have access to the files, which are secured in the unit coordinators' offices in the units. Staff added that administrators have access to the files and that direct care staff get information from the unit coordinator in regards to the unit goals. Staff reported when treatment team meetings are conducted, everything is on the table and the resident and parents are invited to participate.

A review of 15 resident files reflected residents are assigned to a housing unit once a review of the screening form documentation is conducted. Each file reflected which staff conducted the housing and room assignment for each resident.

### 115.342(b).

In the PAQ, the agency reported it has a policy that residents at risk of sexual abuse may only be placed in isolation as a last resort if less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all residents safe can be arranged. The agency reported policy requires residents have access to legally required educational programming or special education services, and daily large-muscle exercise. The agency reported no residents at risk of sexual victimization were placed in isolation in the past 12 months.

Agency Policy RS-9.10 Discipline Plan, Section II (H) (*p. 3*) defines protective isolation as the isolation of a physically threatened resident from the group by placing the resident in an individual room, which minimizes contact with other residents from a specific group.

During the onsite review, staff reported there are no holding cells, segregated housing units, or isolation rooms. The facility does not have a formal "intake" (receiving/discharge) area. Residents currently housed at the facility are sent directly from the pre-adjudication facility. Any personal belongings are released to the parents/guardians of the resident prior to the resident being moved to the post-adjudication facility. There are no designated isolation rooms. Each housing unit has one "Time Out" room that allows for a resident to be secured as needed when addressing behavioral issues or concerns. While onsite, the auditor observed the "Time Out" room being used only once. The resident observed in the "Time Out" room agreed to be interviewed by the auditor.

Staff interviewed reported they do not isolate, as a practice, victims of sexual abuse. For the staff, that would be punishment for the kids coming forth. Staff reported residents placed in isolation have access to programs, privileges, education/special education, and work opportunities. Staff stated, "I have never been a part of that," when asked if residents are placed in involuntary isolation only until an alternative means of separation from likely abusers can be arranged. Staff added they would assume they would do this to get the resident away from the abuser but added this has not happened. Staff added residents would be in isolation no more than one hour. Staff reported medical/mental health would immediately visit the resident if they need to be isolated just to evaluate them and would determine how long should wait to come back and see them. Staff added if the resident asks for medical or mental health staff, both would respond at any time. Medical and mental health staff reported residents in isolation would be visited during all three shifts (24/7 service), plus conduct sick calls twice a day. Staff stated, "Culture is not to isolate; would have multiple people check in with the resident."

**115.342(c).**

In the PAQ, the agency reported it prohibits placing lesbian, gay, bisexual, transgender, or intersex residents in particular housing, bed or other assignments solely on the basis of such identification or status. It also prohibits considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator or likelihood of being sexually abusive.

Agency Policy AS-1203 LGBTQI Juveniles, Section III (E) (pp. 4-5) states, "LGBTQI juveniles will not be placed in particular housing, bed or other assignments solely on the basis of identification or status." A subsequent subsection states, "LGBTQI identification or status will not be considered an indicator or likelihood of being sexually abusive."

Staff interviewed reported they do not have special housing units for lesbian, gay, bisexual, transgender, or intersex residents. At the time of the audit, the agency reported there were no lesbian, gay, bisexual, transgender, or intersex residents who are currently being housed at the facility.

**115.342(d).**

In the PAQ, the agency reported it makes housing and program assignments for transgender or intersex resident on a case-by-case basis.

Agency Policy AS-1203 LGBTQI Juveniles, Section III (F.1) (p. 5) states, "The MDT will develop the Individual Classification Plan (ICP) for each transgender and intersex juvenile on a case-by-case basis.

Staff interviewed reported they determine housing and program assignments for transgender or intersex residents during intake. The MDT would consider the information. The resident, administration, and the compliance team are involved in regards to the safety of the resident and the safety of the others. Staff reported they would certainly consider the resident's health and safety. Staff stated, "We are in the business of rehabilitating kids and we want them to be comfortable." Staff also reported they would definitely consider whether the placement would present management or security problems. At the time of the audit, the agency reported there were no transgender, or intersex residents who are currently being housed at the facility.

**115.342(e).**

Agency Policy AS-1203 LGBTQI Juveniles, Section III (F.6) (p. 6) states, "Placement and programming assignments for each transgender or intersex juvenile will be reassessed at least twice each year to review any threats to safety experienced by the resident."

Staff interviewed reported if there is a concern (incident or allegation), it would be considered, as well as reassess any threats to safety experienced by the resident every 30 days. Staff also reported reassessments would be done sooner. Staff reported there had been no transgender residents placed at the facility in the past 12 months.

**115.342(f).**

Agency Policy AS-1203 LGBTQI Juveniles, Section III (F.4) (p. 5) states, “Serious consideration will be given to each transgender or intersex juvenile’s own view of his or her safety.”

Staff interviewed reported they would take the resident’s own view into consideration. Staff reported they want them to be successful and would consider their own wishes, plus help them understand it for their and other child’s safety. At the time of the audit, the agency reported there were no transgender, or intersex residents who are currently being housed at the facility.

**115.342(g).**

Agency Policy AS-1203 LGBTQI Juveniles, Section III (G) (p. 6) allows for transgender and intersex juveniles the opportunity to disrobe, shower, and dress apart from other juveniles.

During the onsite review, the auditor noted that each housing unit has a combined shower/restroom. Staff reported residents are allowed to use the room only one at a time. At the time of the audit, the agency reported there were no transgender, or intersex residents who are currently being housed at the facility.

Staff interviewed reported all residents shower and use the restroom one at a time. At the time of the audit, the agency reported there were no transgender, or intersex residents who are currently being housed at the facility.

**115.342(h).**

In the PAQ, the agency reported there were no cases of residents at risk of sexual victimization that were held in isolation in the past 12 months.

**115.342(i).**

In the PAQ, the agency reported if a resident at risk of sexual victimization is held in isolation, the facility affords each resident a review every 30 days to determine whether there is a continuing need for separation from the general population.

Staff interviewed stated, “No resident has been placed in involuntary isolation under these circumstances ever to my knowledge.” At the time of the audit, the agency reported there were no residents in isolation (for risk of sexual victimization/who alleged to have suffered sexual abuse) who are currently being housed at the facility.

**Corrective Action:**

1. The auditor recommends no corrective action.

## REPORTING

## Standard 115.351: Resident reporting

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

#### 115.351 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment?  Yes  No
- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment?  Yes  No
- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents?  Yes  No

#### 115.351 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency?  Yes  No
- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials?  Yes  No
- Does that private entity or office allow the resident to remain anonymous upon request?  Yes  No
- Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment?  Yes  No

#### 115.351 (c)

- Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties?  Yes  No
- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment?  Yes  No

#### 115.351 (d)

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

#### 115.351 (e)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

### The following evidence was analyzed in making the compliance determination:

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
  - b. AS-901 Reporting of Child Abuse, Neglect, and Exploitation (*revised 12/1/16*)
  - c. Travis County Juvenile Probation Residential Services Program Manual ISC (Resident Handbook) (*revised 7/31/17*)
  - d. TCJPD Residential Services Resident Handbook (*revised 1/9/19*)
  - e. Texas Administrative Code Chapter 350 (*effective 9/1/09*)
  - f. AS-902 Preventing and Detecting Sexual Abuse and Sexual Harassment (*revised 6/12/17*)
  - g. RS-2.50 First Responder Duties (*revised 6/12/17*)
  - h. AS-401 Staff Training and Development Plan (*revised 6/8/15*)
  - i. Memo (*dated 1/25/19*)
  - j. Mexican Consular Contact and Homeland Security, Austin, Texas
2. Interviews:
  - a. PREA Compliance Manager
  - b. Random Sample of Staff
  - c. Residents who Reported a Sexual Abuse
  - d. Residents
3. Onsite Review:
  - a. Housing Units, Library, Dining (2), Visitation, and Corridors

### Findings (By Provision):

**115.351(a).**

In the PAQ, the agency reported it has established multiple internal ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents.

Agency Policy AS-901 Reporting of Child Abuse, Neglect, and Exploitation, Section III (A.2) (p. 3) addresses the multiple internal ways for residents to report allegations to agency officials. Section III (E.1) (p.9) requires the posting of the zero tolerance policy informing residents they have unimpeded access to report allegations directly to TJJD. The resident handbook informs resident they can report abuse to TJJD (p. 26). The handbook further informs the residents, if they feel their rights have been violated, they can write a grievance. The handbook (p. 26) informs the residents they have a right not to be retaliated against for reporting incidents, but does not clearly state they can report retaliation by other residents or staff for reporting sexual abuse and sexual harassment. The revised resident handbook "Resident Rights" section (p. 17) addresses retaliation; and "Abuse Education" sections (p. 20) outlines all the abuse related incidents, including the three elements listed in this provision, and encourages residents to report the incidents immediately.

During the onsite review, the auditor noted the required zero tolerance policy posters (English and Spanish) throughout the facility – in the housing units (including vacant housing units), corridors, library, classrooms, and dining rooms. There were a couple of areas where one or both posters were not posted, but staff quickly found and posted new posters.

The auditor interviewed 12 randomly selected staff from all three shifts. One of the staff had just been hired within the past two weeks and was pending the completion of the training and reported being at the facility under constant supervision by a supervisor and currently participating in on-the-job training. With the exception of the newly hired staff, the remaining 11 staff reported residents could call the hotline (TJJD), file a grievance, or tell staff. Eleven (10 male; one female) residents were interviewed, with nine of the residents randomly selected. All residents stated they would report sexual abuse and sexual harassment by calling the hotline. Of the 11 residents interviewed, 10 reported they would tell staff, and six reported they would file a grievance.

**115.351(b).**

In the PAQ, the agency reported it provides at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency. The agency also reported it has a policy requiring residents detained solely for civil immigration purposes be provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or sexual harassment.

Agency Policy AS-901 Reporting of Child Abuse, Neglect, and Exploitation, Section III (A.2.a.4) (p. 3) addresses access to TJJD, DSHS, and SafePlace. The initial resident handbook did not inform residents they can report allegations to SafePlace and only informs the residents the SafePlace hotline can give emotional support and access to counseling. The resident handbook (pp. 29-30) states, "You will be allowed to report by phone at a reasonable time upon your request." The handbook lists the following as outside entities: TJJD, the Department of Family and Protective Services (DFPS), and DSHS. The revised resident handbook (p. 22) includes the contact information for SafePlace.

Agency Policy RS-2.50 First Responder Duties, Section III (A.1.c) (p. 3) addresses access to TJJD, and DSHS. Agency Policy AS-902 Preventing and Detecting Sexual Abuse and Harassment, Section III (G.6) (p. 7) addresses residents detained solely for civil immigration purposes. The review of the initial resident handbook reflected it did not include information on how to contact relevant consular officials

and relevant officials at the Department of Homeland Security to report sexual abuse or sexual harassment and the auditor inquired if residents would be detained solely for civil immigration purposes. The agency reported it does not detain residents solely for civil immigration purposes. The agency also responded and reported measures are taken to ensure residents are informed of this information, via a memo dated 1/25/19, which states, "Residents are adjudicated by a Juvenile Court Judge and assigned treatment to the Residential Services program. Residents are not detained solely for civil immigration purposes. However, residents are provided information on how to contact relevant consular officials and / or relevant officials at the Department of Homeland Security. See Texas Family Code below: Texas Family Code – FAM § 54.011. Detention Hearings for Status Offenders and Non-offenders; Penalty (a) The detention hearing for a status offender or non-offender who has not been released administratively under Section 53.02 shall be held before the 24<sup>th</sup> hour after the time the child arrived at a detention facility, excluding hours of a weekend or a holiday. Except as otherwise provided by this section, the judge or referee conducting the detention hearing shall release the status offender or non-offender from secure detention. Texas Family Code – FAM § 54.02. Definitions (8) "Non-offender" means a child who: B) has been taken into custody and is being held solely for deportation out of the United States." The agency provided the contact information for the Mexican Consular Contact and Homeland Security, Austin, Texas.

During the onsite review, the auditor tested the phones and was able to access the hotline directly. The auditor also conducted a test to determine if the outside agency (TJJD) was able to receive and immediately forward resident reports of sexual abuse and sexual harassment to an agency official. Once the test was activated, the outside agency responded to the PREA Coordinator and CJPO within 11 minutes.

Staff interviewed reported residents can privately report allegations through the hotline, grievance system, a third party, attorney and therapist. Staff reported residents' reports can remain anonymous when reported to the hotline or grievance. Eleven (10 male; one female) residents were interviewed, with nine of the residents randomly selected. When asked who they would make a report to someone outside of the agency, all the residents reported they would tell their mom, parents or family. Five of the eleven residents were not sure if they could make a report anonymously.

#### **115.351(c).**

In the PAQ, the agency reported staff members accept and immediately, but no later than the end of their shift, document reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties.

Agency Policy AS-901 Reporting of Child Abuse, Neglect, and Exploitation, Section III (A.2) (p. 3) and Agency Policy RS-2.50 First Responder Duties, Section III (A.1.c) (p. 3) address staff members accepting reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties. Agency Policy AS-901 Reporting of Child Abuse, Neglect, and Exploitation, Section III (C.4) (p. 7) states, "If an ANE allegation is received from an anonymous source .. staff ... make the required notifications and reports." The provision applies to "verbal" reports being documented. Agency Policy Agency Policy RS-2.50 First Responder Duties, Section III (A.1.e) (p. 3) addresses the requirement staff members document any allegations made using the serious incident report.

The auditor interviewed 12 randomly selected staff from all three shifts. One of the staff had just been hired within the past two weeks and was pending the completion of the training and reported being at the facility under constant supervision by a supervisor and currently participating in on-the-job training. With the exception of the newly hired staff, the remaining 11 staff reported residents could make reports verbally, in writing, anonymously, or through third party and 10 reported they would document it

immediately. One staff was not sure about the requirement to document the reported incident. Eleven (10 male; one female) residents were interviewed, with nine of the residents randomly selected. All residents stated they would make reports of sexual abuse and sexual harassment in person or in writing. Two residents reported they would not tell anyone else, and the remaining residents reported they would ask staff or peers to assist.

**115.351(d).**

In the PAQ, the agency reported it provides residents with access to tools necessary to make a written report. Agency Policy AS-901 Reporting of Child Abuse, Neglect, and Exploitation, Section III (A.2.a) (p. 3) and Agency Policy RS-2.50 First Responder Duties, Section III (A.1.a) (p. 3) address granting access to the necessary tools for residents to make reports.

Staff interviewed reported the tools the facility provides residents to help them make reports include the grievance form and access to the grievance officer. Residents also have access to the TJJD hotline, including contact information on the PREA posters and the Safe Alliance Group Hotline, which is also posted. Staff reported residents also have access to the therapists. A resident who reported a sexual abuse incident was interviewed. The resident reported he did not make a written report. He indicated that TJJD wrote up the report and he was not asked to write anything down.

**115.351(e).**

In the PAQ, the agency reported it provides a method for staff to privately report sexual abuse and sexual harassment of residents. The agency also reported staff may report outside their chain of command and/or call the TJJD hotline. Agency Policy AS-401 Staff Training and Development Plan, Section III (F.2.10 and F.5) address the training requirement on the staff's reporting requirements.

The auditor interviewed 12 randomly selected staff from all three shifts. One of the staff had just been hired within the past two weeks and was pending the completion of the training and reported being at the facility under constant supervision by a supervisor and currently participating in on-the-job training. With the exception of the newly hired staff, the remaining 11 staff reported they would call the hotline, tell the PREA Coordinator, a supervisor, or management.

**Corrective Action:**

1. The agency revised the resident handbook to include residents can also report retaliation by other residents or staff for reporting sexual abuse and sexual harassment and staff neglect or violation of responsibilities that may have contributed to such incidents. The revised handbook includes the contact information for SafePlace.

**Standard 115.352: Exhaustion of administrative remedies**

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

**115.352 (a)**

- Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of

explicit policy, the agency does not have an administrative remedies process to address sexual abuse.  Yes  No  NA

#### 115.352 (b)

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

#### 115.352 (c)

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

#### 115.352 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.)  Yes  No  NA
- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)], does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.)  Yes  No  NA
- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.)  Yes  No  NA

#### 115.352 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)  Yes  No  NA

- Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.)  Yes  No  NA
- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)  
 Yes  No  NA
- Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.)  Yes  No  NA
- If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.)  Yes  No  NA

#### 115.352 (f)

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

## 115.352 (g)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

### The following evidence was analyzed in making the compliance determination:

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
  - b. Memo – 115.352 (*dated 9/14/18*)
  - c. AS-904 Corrective Action and Notifications (*revised 12/1/16*)
  - d. RS-6.160 Grievance Procedures (*revised 2/19/16*)
  - e. RS-2.50 First Responder Duties (*revised 6/12/17*)
  - f. Travis County Juvenile Probation Residential Services Program Manual ISC (Resident Handbook) (*revised 7/31/17*)
  - g. AS-1202 Juvenile Grievances Procedures (*revised 2/19/16*)
  - h. TCJPD Residential Services Resident Handbook (*revised 1/9/19*)
2. Interviews:
  - a. Residents who Reported a Sexual Abuse
  - b. Administrative Staff

### Findings (By Provision):

#### 115.352(a).

In the PAQ, the agency reported it has administrative procedures to address resident grievances regarding sexual abuse.

Memo – 115.352 states, "Residents are informed of their right to access the grievance process during orientation. If a resident uses the grievance system to inform the staff of any allegations of abuse,

neglect or exploitation, to include sexual abuse and sexual harassment (ANE) that portion of the grievance will be administratively closed by the initiation of an administrative and / or criminal investigation. Any other element of the grievance will be addressed in accordance with the grievance policies. . . From October 30, 2017 to September 14, 2018, there have not been any resident or third party allegations of sexual abuse or sexual harassment submitted using the grievance process. Additionally, there have not been any allegations of substantial risk of imminent sexual abuse during that same time.”

Agency Policy RS-6.160 Grievance Procedures does not apply to this standard. Agency Policy AS-1202 Juvenile Grievance Procedures, Section III (B.1.a.i) (p. 1) addresses this standard and states, “Juveniles may not be required to use any informal grievance process if there is an alleged incident of any type of abuse, neglect or exploitation, to include sexual abuse.” Section III (G.3.a.i-iii) (pp. 5-6) require that abuse complaints be reported in accordance with Agency Policy AS-901; grievances that include allegations of abuse “be resolved by indicating that the allegation will be investigated as outlined in policy AS-217: Administrative Investigations; and states, “Any element of the grievance that does not allege abuse, neglect or exploitation will be addressed accordingly.”

Administrative staff interviewed reported all sexual abuse and sexual harassment allegations received as a grievance do not continue through the grievance process and are referred for an investigation. To ensure clear written communication to the residents, the Resident Handbook “**STEPS TO FILLING OUT A GRIEVANCE**” form (p. 19) was revised to state, “The following are the steps you can take to resolve your issue. 1) Try and resolve your complaint with staff before asking for a grievance. (Unless it is an alleged incident of sexual abuse).” The auditor has determined the agency does not have an administrative remedies process to address sexual abuse and is exempt from this standard. The subsequent provisions are found to be not applicable.

**115.352(b).**

The auditor has determined the agency does not have an administrative remedies process to address sexual abuse and is exempt from this standard. This provision is found to be not applicable.

**115.352(c).**

The auditor has determined the agency does not have an administrative remedies process to address sexual abuse and is exempt from this standard. This provision is found to be not applicable.

**115.352(d).**

The auditor has determined the agency does not have an administrative remedies process to address sexual abuse and is exempt from this standard. This provision is found to be not applicable.

**115.352(e).**

The auditor has determined the agency does not have an administrative remedies process to address sexual abuse and is exempt from this standard. This provision is found to be not applicable.

**115.352(f).**

The auditor has determined the agency does not have an administrative remedies process to address sexual abuse and is exempt from this standard. This provision is found to be not applicable.

**115.352(g).**

The auditor has determined the agency does not have an administrative remedies process to address sexual abuse and is exempt from this standard. This provision is found to be not applicable.

**Corrective Action:**

1. The auditor recommends no corrective action.

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

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

**115.353 (a)**

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making assessable mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations?  Yes  No
- Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies?  Yes  No
- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible?  Yes  No

**115.353 (b)**

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

**115.353 (c)**

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

**115.353 (d)**

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

## Auditor Overall Compliance Determination

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

## Instructions for Overall Compliance Determination Narrative

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

### The following evidence was analyzed in making the compliance determination:

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
  - b. AS-901 Reporting of Child Abuse, Neglect, and Exploitation (*revised 12/1/16*)
  - c. AS-905 Services for Victims of Sexual Abuse (*revised 2/19/16*)
  - d. RS-6.210 Telephone Calls (*revised 6/8/15*)
  - e. Memorandum of Understanding (MOU) with SafePlace (*dated 9/8/14*)
  - f. Memorandum of Understanding (MOU) with SafePlace (*dated 2/22/19*)
  - g. TCJPD Residential Services Resident Handbook (*revised 1/9/19*)
  - h. Memo (*dated 1/25/19*)
  - i. Mexican Consular Contact and Homeland Security, Austin, Texas
  - j. Resident File
2. Interviews:
  - a. Superintendent
  - b. PREA Compliance Manager
  - c. SAFE/SANE Staff
  - d. Residents who Reported a Sexual Abuse
  - e. Residents
3. Onsite Review:
  - a. Housing Units, Library and Visitation

### Findings (By Provision):

#### **115.353(a).**

In the PAQ, the agency reported it provides residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making assessable mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations. The agency reported

it provides persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies. The agency also reported it provides reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible. Agency Policy AS-905 Services for Victims of Sexual Abuse, Section III (C.4) (p. 3) states, "Services will be made available to the victim whether or not he or she is still in the physical custody of the facility." Section III (E.2) (p. 4) provides for allowing residents access to the mailing addresses and phone numbers of the victim advocacy or rape crisis organizations.

Agency Policy AS-902 Preventing and Detecting Sexual Abuse and Harassment, Section III (G.6) (p. 7) addresses residents detained solely for civil immigration purposes. The review of the initial resident handbook reflected it did not include information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or sexual harassment and the auditor inquired if residents would be detained solely for civil immigration purposes. The agency reported it does not detain residents solely for civil immigration purposes. The agency also responded and reported measures are taken to ensure residents are informed of this information, via a memo dated 1/25/19, which states, "Residents are adjudicated by a Juvenile Court Judge and assigned treatment to the Residential Services program. Residents are not detained solely for civil immigration purposes. However, residents are provided information on how to contact relevant consular officials and / or relevant officials at the Department of Homeland Security. See Texas Family Code below: Texas Family Code – FAM § 54.011. Detention Hearings for Status Offenders and Non-offenders; Penalty (a) The detention hearing for a status offender or non-offender who has not been released administratively under Section 53.02 shall be held before the 24<sup>th</sup> hour after the time the child arrived at a detention facility, excluding hours of a weekend or a holiday. Except as otherwise provided by this section, the judge or referee conducting the detention hearing shall release the status offender or non-offender from secure detention. Texas Family Code – FAM § 54.02. Definitions (8) "Non-offender" means a child who: B) has been taken into custody and is being held solely for deportation out of the United States." The agency provided the contact information for the Mexican Consular Contact and Homeland Security, Austin, Texas.

Eleven (10 male; one female) residents were interviewed, with nine of the residents randomly selected. Of the ten residents interviewed, four reported they were not aware of any services available outside the facility for dealing with sexual abuse, if they needed it. Two residents reported being aware of SafePlace or had seen the posted information. Two residents stated they would still go to their parents, and two reported they would not ask for help. A resident who had reported a sexual abuse incident reported receiving information on SafePlace but did not want to pursue nor requested any services. The resident reported he knew he could talk with SafePlace confidentially.

During the onsite review, the auditor noted that SafePlace information was posted in each housing unit.

#### **115.353(b).**

In the PAQ, the agency reported it informs residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. Agency Policy AS-905 Services for Victims of Sexual Abuse, Section III (E..4) (p. 4) states, "To the extent allowable by local, state and federal law, the communications will be private. Prior to the contact, the victim will be informed of the extent of the confidentiality or privilege allowed."

A resident who had reported a sexual abuse incident reported they would keep it confidential (was referring to TJJD). The resident reported receiving information on SafePlace but did not want to pursue

nor requested any services, therefore no services were provided. A review of the resident's file reflected staff documented providing the resident with the information about SafePlace and the phone number.

**115.353(c).**

In the PAQ, the agency reported it maintains a copy of an agreement with a community service provider that is able to provide residents with confidential emotional support services related to sexual abuse

The agency has an MOU with SafePlace. The MOU provides for "Staff a confidential victim support services hotline seven (7) days a week to provide crisis intervention services and / or emotional support to juveniles who experience sexual abuse, harassment or violence while in the custody of TCJPD or at some other time whether or not it was previously reported."

The interview with SANE/SAFE staff indicated they are not sure about emotional support services related to sexual abuse if not related to forensic medical exam event. The MOU was modified subsequent to the interview with the SAFE/SANE staff to ensure services provided would also include emotional support services related to any sexual abuse event.

**115.353(d).**

In the PAQ, the agency reported it provides residents with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians. Agency Policy RS-6.210 Telephone Calls, Section I (p. 1) states, "Residents will have equal access to telephone usage to facilitate communication with their families and legal representatives. Section III (B.5) (p. 2) addresses residents being afforded reasonable and confidential access to their legal counsel via telephone at any appropriate time of the day.

During the onsite review, the auditor observed the visitation room where attorneys, parents or legal guardians can visit with the resident. Staff interviewed reported residents can have access to their attorneys or legal representation by having their probation officer contact the attorney, facility staff can make the request on the behalf of the resident, or the resident can send a letter to their attorney. Staff also reported residents can call their attorney. Staff reported visitation with a parent or legal guardian is every Saturday and Sunday. Residents can also mail letters or make phone calls to their parents. Residents at certain levels get additional calls. Staff conduct family sessions with the resident as part of the treatment. Staff also reported residents can call their family on a daily basis based on their level system.

Eleven (10 male; one female) residents were interviewed, with nine of the residents randomly selected. All of the residents interviewed, including the resident who reported a sexual abuse, reported they can privately visit with their attorney and can see their parents during visitation once a week or call them daily. One resident reported being a parent and being allowed to visit with their child during visitation.

**Corrective Action:**

1. The MOU was modified to include the provision for emotional support services related to sexual abuse.

## Standard 115.354: Third-party reporting

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

## 115.354 (a)

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment?  Yes  No
- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident?  Yes  No

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

### The following evidence was analyzed in making the compliance determination:

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
  - b. AS-901 Reporting of Child Abuse, Neglect, and Exploitation (*revised 12/1/16*)
  - c. *Notice of Public Complaint Process Form*
  - d. Investigative Files
2. Onsite Review:
  - a. Visitation

### Findings (By Provision):

#### 115.354(a).

In the PAQ, the agency reported it provides a method to receive third-party reports of sexual abuse and sexual harassment and that it distributes information on how to report sexual abuse and sexual harassment on behalf of a resident.

Agency Policy AS-901 Reporting of Child Abuse, Neglect, and Exploitation, Section III (A.1) (*p. 3*) addresses staff will accept third party allegations. During the onsite review, the auditor noted the *Notice of Public Complaint Process Form* serves as the "Third Party" information and is posted in the visitation room. The form was updated during the post-onsite audit phase. A review of the investigative files reflected both incidents were reported by a third-party. One allegation was reported by a resident

and the second allegation was reported by staff, both of which became aware of the incident and reported it.

**Corrective Action:**

1. The auditor recommends no corrective action.

## OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

### Standard 115.361: Staff and agency reporting duties

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

#### 115.361 (a)

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency?  Yes  No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment?  Yes  No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation?  Yes  No

#### 115.361 (b)

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

#### 115.361 (c)

- Apart from reporting to designated supervisors or officials and designated State or local services agencies, are staff prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions?  Yes  No

#### 115.361 (d)

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

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

#### 115.361 (e)

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office?  Yes  No
- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified?  Yes  No
- If the alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? (N/A if the alleged victim is not under the guardianship of the child welfare system.)  Yes  No  NA
- If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation?  Yes  No

#### 115.361 (f)

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

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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

#### The following evidence was analyzed in making the compliance determination:

1. Documents:

- a. Pre-Audit Questionnaire (PAQ)
- b. AS-901 Reporting of Child Abuse, Neglect, and Exploitation (*revised 12/1/16*)
- c. AS-904 Corrective Action and Notifications (*revised 12/1/16*)
- d. AS-217 Administrative Investigations (*revised 12/1/16*)
- e. TCJPD Internal Investigation Checklist Form (*revised 11/18*)

2. Interviews:

- a. Superintendent
- b. Medical and Mental Health Staff
- c. Random Staff

**Findings (By Provision):**

**115.361(a).**

In the PAQ, the agency reported it requires all staff to report immediately and according to agency policy (1) any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; (2) any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment; and (3) any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation.

Agency Policy AS-901 Reporting of Child Abuse, Neglect, and Exploitation, Section III (A) (p. 3) and Section III (C.1) (p. 5) address immediate reporting requirements of staff and who to notify. Agency Policy AS-904 Corrective Action and Notifications, Section III (G) (pp. 5-6) addresses prohibition against retaliation against any individual who reports sexual abuse or sexual harassment or who cooperates with an investigation. Agency Policy AS-217 Administrative Investigations, Section III (H) (p. 3) addresses staff protections for reporting staff misconduct or cooperating in an investigation. Agency Policy AS-904 Corrective Action and Notifications, Section III (G) (p. 5) addresses the prohibition of retaliation against any individual reports sexual abuse or sexual harassment. Section III (G.3) (p. 6) states, "The Chief or designee will appoint of an individual to monitor staff members to prevent harassment, discrimination or retaliation due to their report or cooperation with an investigation."

The auditor interviewed 12 randomly selected staff from all three shifts. One of the staff had just been hired within the past two weeks and was pending the completion of the training and reported being at the facility under constant supervision by a supervisor and currently participating in on-the-job training. All staff, including the newly hired staff, reported they are required to immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment, retaliation against residents or staff who reported such an incident, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Staff stated they would report any incidents to their supervisors and/or call the hotline (TJJD).

**115.361(b).**

In the PAQ, the agency reported it requires all staff to comply with any applicable mandatory child abuse reporting laws. Agency Policy AS-901 Reporting of Child Abuse, Neglect, and Exploitation, Section III (A.5) (p. 4) addresses the mandatory reporting requirement per Texas Family Code 261.101.

The auditor interviewed 12 randomly selected staff from all three shifts. One of the staff had just been hired within the past two weeks and was pending the completion of the training and reported being at the facility under constant supervision by a supervisor and currently participating in on-the-job training. With the exception of the newly hired staff, nine of the remaining 11 staff reported being aware of the agency's policies and procedures and reporting/responding requirements.

**115.361(c).**

In the PAQ, the agency reported staff are prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions. Agency Policy AS-901 Reporting of Child Abuse, Neglect, and Exploitation, Section III (A.8) (p. 4) addresses staff confidentiality requirements.

The auditor interviewed 12 randomly selected staff from all three shifts. One of the staff had just been hired within the past two weeks and was pending the completion of the training and reported being at the facility under constant supervision by a supervisor and currently participating in on-the-job training. All staff, including the newly hired staff, reported they are required to immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment, retaliation against residents or staff who reported such an incident, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Staff stated they would report any incidents to their supervisors and/or call the hotline (TJJD).

**115.361(d).**

Medical and mental health staff interviewed reported they do disclose the limitations of confidentiality and their duty to report. Staff reported they would do this right away. Staff stated they are required to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment and would notify the CJPO, Deputy CJPO, Compliance Unit, a supervisor, CPS and the TCSO. Staff reported they were not aware of any such incidents.

**115.361(e).**

Staff interviewed reported when they receive an allegation of sexual abuse, they report it to TJJD, law enforcement, and internally, it is reported to the agency's General Counsel and Deputy Chief. They would also notify the resident's parent/guardian or the CPS worker, if the resident is in the custody of CPS. Staff reported TJJD is notified within four hours and law enforcement would be notified in one hour. The resident's case manager would also be notified. Staff reported the assigned juvenile probation officer would be notified and that individual would notify the resident's attorney, but recently realized this was not being done.

A review of two investigative files reflected the following: In one case, the parent was notified but the resident's attorney was not notified. A review of the second file reflected CPS was notified as required. In both cases, TJJD was notified as required. The *TCJPD Internal Investigation Checklist* Form was revised to include an additional notification element be documented to ensure staff notify the alleged victim's attorney within 14 days when the alleged victim is under the juvenile court's jurisdiction.

**115.361(f).**

Staff interviewed reported all allegations of sexual abuse and sexual harassment, including from third-party and anonymous sources, are reported to the facility's investigators: Deputy Chief and General Counsel.

**Corrective Action:**

1. The agency revised the *TCJPD Internal Investigation Checklist* Form to include an additional subsection documenting the notification of the alleged victim's attorney within 14 days, if the victim is under the juvenile court's jurisdiction.

## Standard 115.362: Agency protection duties

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

### 115.362 (a)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

### The following evidence was analyzed in making the compliance determination:

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
  - b. Memo – 115.362 (*dated 9/13/18*)
  - c. AS-903 First Responder Duties (*dated 6/12/17*)
  - d. AS-901 Reporting of Child Abuse, Neglect, and Exploitation (*revised 12/1/16*)
  - e. RS-2.50 First Responder Duties (*revised 6/12/17*)
2. Interviews:
  - a. Agency Head
  - b. Superintendent
  - c. Random Staff

### Findings (By Provision):

#### 115.362(a).

In the PAQ, the agency reported when it learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident. The agency reported there were no instances in which the agency or facility determined that a resident was subject to a substantial risk of imminent sexual abuse in the past 12 months. Agency Memo – 115.352 states, “From October 30, 2017 to September 13, 2018, there have not been any indications or allegations that a resident subject to substantial risk of imminent sexual abuse. If a resident was determined to be at risk, immediate steps would be taken to protect the resident pursuant to Department policies.”

Agency Policy AS-903 First Responder Duties, Section III (B) (p. 4) addresses the required staff response if staff learns that a juvenile is at imminent risk of sexual abuse. Section III (F.1.d.) (p. 7) addresses the steps to be taken to minimize the disruption to the scene of the alleged assault. Agency Policy RS-2.50 First Responder Duties Section III (B) (p. 4) addresses the required staff response if staff learns that a juvenile is at imminent risk of sexual abuse.

Staff interviewed reported the immediate protective action the facility would take is to protect the resident. They would investigate and contact the General Counsel and determine what action to take. They would not use isolation of the resident as it is used only for behavioral issues. They would determine the need to “keep close” to the resident, so that the resident does not get harassed by other residents. Staff would respond and act immediately; that would be the expectation. Interviews would be conducted to determine what is going on. As much as possible, and within two days, they would have a plan in place and institute the steps to be taken.

The auditor interviewed 12 randomly selected staff from all three shifts. One of the staff had just been hired within the past two weeks and was pending the completion of the training and reported being at the facility under constant supervision by a supervisor and currently participating in on-the-job training. With the exception of the newly hired staff, the remaining 11 staff reported they would respond as follows: report the situation to their supervisor; secure the resident in his room (staff can lock door, but resident can still come out of the room); use the “Time Out” room; remove the resident from the unit; report it for an investigation; and stay with the resident to ensure safety. All reported they would act immediately.

**Corrective Action:**

1. The auditor recommends no corrective action.

## **Standard 115.363: Reporting to other confinement facilities**

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

#### **115.363 (a)**

- Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred?  Yes  No
- Does the head of the facility that received the allegation also notify the appropriate investigative agency?  Yes  No

**115.363 (b)**

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

**115.363 (c)**

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

**115.363 (d)**

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

**Auditor Overall Compliance Determination**

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
  - b. Memo – 115.363 (*dated 9/13/18*)
  - c. AS-901 Reporting of Child Abuse, Neglect, and Exploitation (*revised 12/1/16*)
2. Interviews:
  - a. Agency Head
  - b. Superintendent

**Findings (By Provision):**

**115.363(a).**

In the PAQ, the agency reported it has a policy requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred. The agency reported its policy also requires the head of the facility notify the appropriate

investigative agency. The agency reported no allegations were received by the facility that a resident was abused while confined at another facility.

Agency Memo – 115.363 states, “From October 30, 2017 to September 13, 2018, Detention and Residential staff have not been notified of any allegations that a resident was sexually abused or sexually harassed while confined at another facility. If any allegation is made, the notifications and documentation of the notifications would be made pursuant to Department policy.”

Agency Policy AS-901 Reporting of Child Abuse, Neglect, and Exploitation, Section III (D.10.a, c) (p. 9) states, “a. If the allegation was made while a juvenile was in a facility, the Division Director of the facility will communicate the Department’s report.” The policy also states, “c. TDFPS or TJJD will also be notified of the allegation when either have conservatorship.”

While onsite, the agency reported receiving an allegation that a resident was sexually abused while confined at another facility. The agency provided email communication reflecting the other facility was notified of the allegation. The documentation reflected the facility head made the notification.

**115.363(b).**

In the PAQ, the agency reported agency policy required that the facility head provide such notification provided as soon as possible, but no later than 72 hours after receiving the allegation. Agency Policy AS-901 Reporting of Child Abuse, Neglect, and Exploitation, Section III (D.10) (p. 9) states, addresses the 72-hour requirement.

While onsite, agency reported receiving an allegation that a resident was sexually abused while confined at another facility. The agency provided email communicating reflecting the other facility was notified of the allegation. The notification was made within the 72-hour requirement.

**115.363(c).**

In the PAQ, the agency reported it documents that it has provided such notification. Agency Policy AS-901 Reporting of Child Abuse, Neglect, and Exploitation, Section III (C.5) (p. 7) states, “Within 72 hours of learning of the allegation, the Chief or designee will communicate the Department’s report to the Chief Juvenile Probation Officer, Facility Administrator or governing body of a department that placed the juvenile in a Travis County facility, program or on interim or permanent supervision.”

While onsite, agency reported receiving an allegation that a resident was sexually abused while confined at another facility. The agency provided documented email communication reflecting the other facility was notified of the allegation by the facility head within 72 hours. The documentation reflected a response from the other facility acknowledging receipt of the notice and the action they were taking in response to the allegation.

**115.363(d).**

In the PAQ, the agency reported its policy requires allegations received from other agencies or facilities are investigated in accordance with the PREA Standards. The agency reported there were no allegations of sexual abuse received from other facilities in the past 12 months.

Staff interviewed reported they had not received any allegations from another agency/facility that involved a resident previously placed at the facility. Staff reported the PREA Coordinator and General Counsel would share the information with the CJPO and would initiate an investigation. The reporting requirements would be followed and they would notify law enforcement and TJJD. Staff also reported a

resident had reported an allegation that occurred at another the facility and the agency was notified of the allegation and the information was provided.

**Corrective Action:**

1. The auditor recommends no corrective action.

**Standard 115.364: Staff first responder duties**

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

**115.364 (a)**

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser?  
 Yes  No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence?  Yes  No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?  Yes  No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?  Yes  No

**115.364 (b)**

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

**Auditor Overall Compliance Determination**

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

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

### Instructions for Overall Compliance Determination Narrative

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

### The following evidence was analyzed in making the compliance determination:

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
  - b. RS-2.50 First Responder Duties (*revised 6/12/17*)
  - c. AS-903 First Responder Duties (*dated 6/12/17*)
  - d. Investigative Files
  
2. Interviews:
  - a. Random Staff
  - b. First Responders
  - c. Residents who Reported a Sexual Abuse

### Findings (By Provision):

#### **115.364(a).**

In the PAQ, the agency reported it has a first responder policy for allegations of sexual abuse. The agency reported there were two allegations reported in the past 12 months that a resident was sexually abused. Of these allegations, neither resulted in staff separating the alleged victim and abuser. Both allegations did not rise to the level requiring the collection of physical evidence.

Agency Policy RS-2.50 First Responder Duties, Section III (D-E) (*pp. 5-6*) outlines the required steps first responders will take. The policy addresses all four elements required of this provision.

The auditor interviewed staff who acted as a first responder. Staff reported the incident did not involve a sexual abuse allegation. Staff reported once she was aware of the allegation, it was reported to the supervisor and the resident's counselor was contacted. Staff reported both residents remained at the facility, which required the development of a safety plan that included constant monitoring and check-ins with the victim until the abuser was discharged. Staff reported when made aware of an allegation, they report it to the supervisor, medical, CPS, TJJJ and the police. The victim is removed from the unit for their safety and instructed not to wash hands and leave their clothes alone. They would be taken to medical right away. Staff would write an incident report.

A resident who reported a sexual abuse incident reported a peer (resident) told a supervisor a week after the incident occurred. After the peer alerted staff about the incident, staff responded right away.

A review of two investigative files reflected staff took immediate action and measures to keep the alleged victim and alleged perpetrators separate at all times.

#### **115.364(b).**

In the PAQ, the agency reported its policy requires that if the first staff responder is not a security staff member, that responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff. The agency reported there were no instances in which non-security staff were first responders in the past 12 months.

Agency Policy RS-2.50 First Responder Duties, Section III (A.1.d) (p. 3) states, "If the juvenile is housed in a facility and the first person of knowledge is not a facility staff, he or she will alert the supervisor on duty immediately.

The auditor interviewed staff who acted as a first responder. Staff reported the incident did not involve a sexual abuse allegation. Staff reported once she was aware of the allegation, it was reported to the supervisor and the resident's counselor was contacted. Staff reported both residents remained at the facility, which required the development of a safety plan that included constant monitoring and check-ins with the victim until the abuser was discharged. Staff reported when made aware of an allegation, they report it to the supervisor, medical, CPS, TJJD and the police. The victim is removed from the unit for their safety and instructed not to wash hands and leave their clothes alone. They would be taken to medical right away. Staff would write an incident report. Two non-security staff interviewed reported they would immediately report the allegation to their supervisor and facility staff.

The auditor interviewed 12 randomly selected staff from all three shifts. One of the staff had been hired within the past two weeks and was pending the completion of the training and reported being at the facility under constant supervision by a supervisor and currently participating in on-the-job training. With the exception of the newly hired staff, six of the remaining 11 staff stated they would secure the scene and provide instructions to the residents in order to preserve any evidence. All staff, including the newly hired staff, indicated they would immediately alert their supervisor, with others indicating they would also contact the agency's PREA Compliance Department (PREA Staff), medical, management, CJPO, TJJD, hotline, and/or TCSO. Staff reported they would remove the resident from the threat, instruct the resident not to remove clothing or use the bathroom, preserve the scene, and write an incident report.

**Corrective Action:**

1. The auditor recommends no corrective action.

**Standard 115.365: Coordinated response**

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

**115.365 (a)**

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

**Auditor Overall Compliance Determination**

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

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

### Instructions for Overall Compliance Determination Narrative

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

### The following evidence was analyzed in making the compliance determination:

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
  - b. RS-2.50 First Responder Duties (*revised 6/12/17*)
  - c. 4-DS-11 First Responder Duties (*revised 6/12/17*)
  - d. First Responder Duties Residential Services
  - e. TCJPD Detention Services First Responder Plan for PREA
2. Interviews:
  - a. Superintendent

### Findings (By Provision):

#### 115.365(a).

In the PAQ, the agency reported it has developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse

Agency Policy RS-2.50 First Responder Duties, Section III (F) (*pp. 5-9*) outlines the steps key personnel will take as part of the coordinated response. The agency provided a First Responder Duties Residential Services, which is the facility's written institutional plan. Agency Policy 4-DS-11 First Responder Duties addresses the first responder duties for the detention facility. The agency provided the TCJPD Detention Services First Responder Plan for PREA, which is the detention facility's written institutional plan.

Staff interviewed reported, when responding to an incident, staff would report the incident to their supervisor. It would then be reported to the facility administrator, TJJD, law enforcement, and for an internal investigation. The victim would be taken to the hospital. Staff would reach out to SafePlace. The room would be secured, evidence would be preserved, and the resident would not be allowed to shower. Staff would await instructions from law enforcement. Law enforcement and TJJD would take the lead as needed. Staff reported they would make sure not to re-traumatize the victim.

### Corrective Action:

1. The auditor recommends no corrective action.

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

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

### 115.366 (a)

- Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted?  Yes  No

### 115.366 (b)

- Auditor is not required to audit this provision.

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

### The following evidence was analyzed in making the compliance determination:

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
2. Interviews:
  - a. Agency Head

### Findings (By Provision):

#### 115.366(a).

In the PAQ, the agency reported it has not entered into or renewed any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted

Staff interviewed reported the agency has not entered into any collective bargaining agreement or renewed any collective bargaining agreement or other agreement. Staff reported they are involved with a compensation process.

**115.366(b).**

Auditor is not required to audit this provision.

**Corrective Action:**

1. The auditor recommends no corrective action.

## **Standard 115.367: Agency protection against retaliation**

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

#### **115.367 (a)**

- Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff?  Yes  No
- Has the agency designated which staff members or departments are charged with monitoring retaliation?  Yes  No

#### **115.367 (b)**

- Does the agency employ multiple protection measures for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services?  Yes  No

#### **115.367 (c)**

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?  Yes  No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Any resident disciplinary reports?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident housing changes?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident program changes?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Negative performance reviews of staff?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Reassignments of staff?  Yes  No
- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need?  Yes  No

#### 115.367 (d)

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

#### 115.367 (e)

- If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation?  
 Yes  No

#### 115.367 (f)

- Auditor is not required to audit this provision.

#### Auditor Overall Compliance Determination

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

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

### Instructions for Overall Compliance Determination Narrative

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

### The following evidence was analyzed in making the compliance determination:

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
  - b. AS-904 Corrective Action and Notifications (*revised 12/1/16*)
  - c. AS-217 Administrative Investigations (*revised 12/1/16*)
  - d. Retaliation Monitoring Form (Revised 3/1/19)
  - e. Residential – Unit Population Sheets
  
2. Interviews:
  - a. Agency Head
  - b. Superintendent
  - c. Designated Staff Member Charged with Monitoring Retaliation
  - d. Residents who Reported a Sexual Abuse
  - e. Residents in Isolation

### Findings (By Provision):

#### **115.367(a).**

In the PAQ, the agency reported it has established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff. The agency has designated the Division Director of Residential Services with the responsibility of monitoring for possible retaliation.

Agency Policy 904 Corrective Action and Notifications, Section III (G) (*pp. 5-6*) addresses the strict prohibition of retaliation against any individual who reports sexual abuse or sexual harassment or who cooperates with an investigation. Section III (G.2-3) (*p. 6*) addresses the appointments of an advocate to monitor victims and staff by the Chief or designee.

Agency Policy AS-217 Administrative Investigations, Section III (H) (*pp. 3-4*) addresses staffs' right to be free from retaliation for reporting staff misconduct or cooperating in an investigation.

#### **115.367(b).**

Staff interviewed reported there is a zero tolerance of retaliation. It is in policy and if it has occurred, staff would be disciplined up to and including termination. Action will be taken to address it. Staff reported monitoring for retaliation is part of an investigation and is discussed. Appropriate actions are taken to alleviate it. Staff reported the policy is shared with staff.

Staff who monitor for retaliation reported they are the first line of defense. If retaliation happens on the floor, they are the first to respond and gather information. They would get incident reports from staff and residents and send the information to the supervisor. Any retaliation resulting from a sexual assault will be reported to TJJD. The same protection would apply to those who cooperate in an investigation. Retaliation incidents involving residents would entail separating the residents, monitoring, and supervision, including increasing number of staff. Incidents involving staff would entail moving staff to another housing unit, different shifts, or move to detention or another department within the agency. If staff are under investigation, administrative staff decide on whether to remove staff. Staff reported they would initiate contact with residents who have reported sexual abuse.

A review of the facility's Residential – Unit Population Sheets reflected staff would document efforts made when monitoring for retaliation. The documentation did not ensure a procedure was established to document the monitoring for retaliation. The agency created and implemented the Retaliation Monitoring Form for the purpose of monitoring, tracking, and documenting retaliation.

**115.367(c).**

In the PAQ, the agency reported it monitors the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff. The agency reported they monitor the conduct or treatment for 90 days or until released. The agency reported it acts promptly to remedy any such retaliation and continues such monitoring beyond 90 days if the initial monitoring indicates a continuing need. The agency reported there were no incidents of retaliation that occurred in the past 12 months.

Agency Policy 904 Corrective Action and Notifications, Section III (G) (*pp. 5-6*) addresses the conduct of the retaliation monitoring of any individual who reports sexual abuse or sexual harassment or who cooperates with an investigation. Section III (G.1) (*p. 5*) requires the protection measures (monitoring) will be made available for at least 90 days following the initial report of sexual abuse or sexual harassment. Section III (G.1.b) (*p. 5*) requires immediate steps be taken if monitoring indicates retaliation. Section III (G.1.d) (*p. 5*) allows for the extension of the monitoring past 90 days.

Staff interviewed reported they follow the Administrative Disciplinary Policy. Staff could face suspension or reassignment while they investigate the situation to determine what course of action to take. Staff who monitor for retaliation reported when monitoring residents, they look for things that have been said, body gesture/movement, fixation on resident that reported. When monitoring staff, they look for the way staff treat residents, blaming of residents, making excuses, how points are given to the residents, and body gestures. When monitoring for retaliation between staff, they look for how they interact with each other, listen to other staff, and word of mouth. Staff reported they will monitor for retaliation for as long as they have to and the situation is settled. They would monitor for one to six months. Even if settled, they will still keep an eye on it until they get feedback from the team, which includes staff, supervisors, and therapists. Staff reported the longest he has monitored a resident was three weeks, which stopped when the resident was removed from the program. Staff reported he has not monitored staff for retaliation.

A review of the facility's Residential – Unit Population Sheets reflected staff would document efforts made when monitoring for retaliation. The documentation did not ensure a procedure was established to document the monitoring for retaliation. The agency created and implemented the Retaliation Monitoring Form for the purpose of monitoring, tracking, and documenting retaliation. The form is designed to monitor for retaliation against residents and staff.

**115.367(d).**

Staff who monitor for retaliation reported when monitoring residents, they look for things that have been said, body gesture/movement, and fixation on the resident that reported. When monitoring staff, they look for the way staff treat residents, blaming of residents, making excuses, how points are given to the residents, and body gestures. When monitoring for retaliation between staff, they look for how they interact with each other, listen to other staff, and word of mouth.

A review of the facility’s Residential – Unit Population Sheets reflected staff would document efforts made when monitoring for retaliation. The documentation did not ensure a procedure was established to document the monitoring for retaliation. The agency created and implemented the Retaliation Monitoring Form for the purpose of monitoring, tracking, and documenting retaliation.

**115.367(e).**

Staff interviewed reported there is a zero tolerance of retaliation. It is in policy and if it has occurred, staff would be disciplined up to and including termination. Action will be taken to address it – separate person involved, add coverage, check-ins. Staff stated, “We mean what we say.” Staff reported monitoring for retaliation is part of an investigation and is discussed. Appropriate actions are taken to alleviate it. Staff interviewed reported they follow the Administrative Disciplinary Policy, which is shared with staff. Staff could face suspension or reassignment while they investigate the situation to determine what course of action to take.

**115.367(f).**

Auditor is not required to audit this provision.

**Corrective Action:**

1. The agency created and implemented the Retaliation Monitoring Form for the purpose of monitoring, tracking, and documenting retaliation.

**Standard 115.368: Post-allegation protective custody**

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

**115.368 (a)**

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

**Auditor Overall Compliance Determination**

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

## Instructions for Overall Compliance Determination Narrative

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

### The following evidence was analyzed in making the compliance determination:

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
  - b. RS-5.100 Discipline Plan (*revised 4/2/14*)
2. Interviews:
  - a. Superintendent
  - b. Staff who Supervise Residents in Isolation
  - c. Medical and Mental Health Staff
  - d. Residents in Isolation (for risk of sexual victimization who allege to have suffered sexual abuse)
3. Onsite Review:

### Findings (By Provision):

#### **115.368(a).**

In the PAQ, the agency reported it has a policy that residents who allege to have suffered sexual abuse may only be placed in isolation as a last resort if less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all residents safe can be arranged. The agency reported there were no residents who alleged to have suffered sexual abuse who were placed in isolation in the past 12 months. The agency reported if a resident who alleges to have suffered sexual abuse is held in isolation, the facility affords such residents a review every 30 days to determine whether there is a continuing need for separation from the general population.

Agency Policy RS-5.100 Discipline Plan, Section II (H) (*p. 2*) includes the following statement as part of the definition for Protective Isolation: "Protective isolation is used as a last resort until alternative means can be arranged." Section III (L) (*p. 12*) addresses the requirement of affording continued programming during protective isolation and required actions the Director will take if protective isolation exceeds 72 hours.

During the onsite review, staff reported there are no holding cells, segregated housing units, or isolation rooms. The facility does not have a formal "intake" (receiving/discharge) area. Residents currently housed at the facility are sent directly from the pre-adjudication facility. Any personal belongings are released to the parents/guardians of the resident prior to the resident being moved to the post-adjudication facility. There are no designated isolation rooms. Each housing unit has one "Time Out" room that allows for a resident to be secured as needed when addressing behavioral issues or concerns. While onsite, the auditor observed the "Time Out" room being used only once. The resident observed in the "Time Out" room agreed to be interviewed by the auditor.

Staff interviewed reported protective custody isolation of residents is not used. Isolation is used for disciplining, but not for sexual abuse/sexual harassment victims. Staff will separate but would not put them in isolation. Staff reported they do not isolate, as a practice, victims of sexual abuse. For the staff, that would be punishment for the kids coming forth. Staff reported residents placed in isolation have access to programs, privileges, education/special education, and work opportunities. Staff stated, "I have never been a part of that," when asked if residents are placed in involuntary isolation only until an alternative means of separation from likely abusers can be arranged. Staff added they would assume they would do this to get the resident away from the abuser but added this has not happened. Staff added residents would be in isolation no more than one hour. Staff reported medical/mental health would immediately visit the resident if they need to be isolated just to evaluate them and would determine how long should wait to come back and see them. Staff added if the resident asks for medical or mental health staff, both would respond at any time. Medical and mental health staff reported residents in isolation would be visited during all three shifts (24/7 service), plus conduct sick calls twice a day. Staff stated, "Culture is not to isolate; would have multiple people check in with the resident." Staff stated, "No resident has been placed in involuntary isolation under these circumstances ever to my knowledge." At the time of the audit, the agency reported there were no residents in isolation (for risk of sexual victimization/who alleged to have suffered sexual abuse) who are currently being housed at the facility.

**Corrective Action:**

1. The auditor recommends no corrective action.

## INVESTIGATIONS

### Standard 115.371: Criminal and administrative agency investigations

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

#### 115.371 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).]  Yes  No  NA
- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).]  Yes  No  NA

#### 115.371 (b)

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

**115.371 (c)**

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data?  Yes  No
- Do investigators interview alleged victims, suspected perpetrators, and witnesses?  
 Yes  No
- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator?  Yes  No

**115.371 (d)**

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

**115.371 (e)**

- When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution?  Yes  No

**115.371 (f)**

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff?  
 Yes  No
- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding?  Yes  No

**115.371 (g)**

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse?  Yes  No
- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings?  Yes  No

**115.371 (h)**

- Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible?  Yes  No

**115.371 (i)**

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

#### 115.371 (j)

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

#### 115.371 (k)

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

#### 115.371 (l)

- Auditor is not required to audit this provision.

#### 115.371 (m)

- When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.321(a).)  Yes  No  NA

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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

#### The following evidence was analyzed in making the compliance determination:

1. Documents:

- a. Pre-Audit Questionnaire (PAQ)
- b. Memo – 115.371 (*dated 8/30/18*)
- c. AS-901 Reporting of Child Abuse, Neglect, and Exploitation (*revised 12/1/16*)
- d. AS-217 Administrative Investigations (*revised 12/1/16*)
- e. AS-217 B Conducting Administrative Investigations (*revised 12/1/16*)
- f. AS-906 Incident Reviews and Data Collection (*effective 2/6/15*)

2. Interviews:

- a. Superintendent
- b. PREA Coordinator
- c. PREA Compliance Manager
- d. Investigative Staff
- e. Resident who Reported a Sexual Abuse

**Findings (By Provision):**

**115.371(a).**

In the PAQ, the agency reported it has a policy related to administrative investigations.

Agency Policy AS-901 Reporting of Child Abuse, Neglect, and Exploitation, addresses reporting requirements and Agency Policy AS-217 Administrative Investigations addresses administrative investigations.

In the Memo – 115.371, the agency reported from November 30, 2017 to present, there have been two different allegations of youth on youth abusive sexual contact. One occurred in April 2018 and the other in July 2018. The April incident resulted in a finding of substantiated for youth on youth sexual harassment. The July incident resulting in a finding of substantiated for youth sexual conduct.

Agency staff interviewed reported an investigation is initiated within 24 hours. Staff reported anonymous or third-party reports of sexual abuse and sexual harassment are not investigated differently from other investigations. Staff stated they have to have enough information if there is no name on the third-party. They would go through the same investigative process. The auditor interviewed the TCSO staff that are responsible for conducting criminal investigations. TCSO staff reported an investigation is initiated as soon as they are notified, which is immediately. Staff reported anonymous or third-party reports are received from the TCJPD staff. Staff reported if a report is received from TJJD, it is referred to Major Crimes. TCSO staff also reported most allegations received are outcries, which do not occur in the facilities.

A review of both investigative files reflected both investigations were initiated within 24 hours of the incident being reported to General Counsel. Both investigations involved resident-on-resident incidents.

**115.371(b).**

Staff interviewed reported receiving the required training in May 2016, plus on-the-job training with his supervisor. Staff interviewed reported receiving training on the Garrity Warning. Staff reported no training was provided on the Miranda Warning, as they do not conduct criminal investigations. Staff reported also receiving training on the juvenile notice, and how to be sensitive towards sexual abuse and sexual harassment victims during the interviews. Staff reported receiving training on all the required topics and added they do not collect the evidence. Staff reported if there is an active crime

scene, they would preserve the scene and contact the TCSO. Staff would never wipe up body fluids. Staff also reported receiving training on the criteria and evidence required to substantiate a case.

A review of three agency's investigator's staff training files, which were the staff that conducted the sexual abuse and sexual harassment investigation files reviewed, reflected all had received the required PREA basic training as well as the specialized training. The auditor interviewed the TCSO staff that are responsible for conducting criminal investigations. The TCSO staff reported receiving the required PREA training through the Sheriff's Office and that PREA updates are provided via a monthly newsletter. Staff reported not being familiar with administrative investigations as they would only handle criminal investigations.

**115.371(c).**

Agency staff interviewed reported the first steps to initiating an investigation would include getting the Serious Incident Report to General Counsel. The CJPO would assign an available investigator. The process takes no more than 24 hours and is usually a top priority when an investigation comes along. Once assigned, the investigator interviews the victim and witness. The Juvenile Notice is given to all juveniles and the Garrity Warning is given to staff. The alleged perpetrator is interviewed last. TJJD requires the investigation be completed in 30 days. The time it takes facility investigators to complete an investigation averages 20 days. Each substantiated and unsubstantiated finding results in an incident review for both sexual abuse and sexual harassment PREA investigations. Staff reported investigators are responsible for the following direct and circumstantial evidence: only written statements, unit assignments, no video, staff rosters, log books, notes passed, websites accessed. Staff stated the TCSO would retain the physical evidence. The auditor interviewed the TCSO staff that are responsible for conducting criminal investigations. The TCSO staff reported they would immediately initiate the investigation and that policy required an investigation be initiated within 24 hours. If the allegation is a sexual abuse, the investigation is initiated immediately; if a Class B offense, the investigation is initiated within 48 hours. Staff reported, once notified, they would conduct interviews, gather evidence, get medical attention for the victim as needed, write the reports, and refer the case to the district attorney's (DAs) office and the Victim's office. Staff reported being responsible for all evidence: physical, DNA, forensic, any evidence gathered at the crime scene. Staff reported being responsible for maintaining the chain of custody, documenting who was at the scene and writing reports.

A review of both investigative files reflected both investigations did not require the collection of DNA evidence. The files reflected interviews of alleged victims, witnesses, and alleged perpetrators were conducted, as well as a review of prior reports and complaints involving the suspected perpetrator.

**115.371(d).**

In the PAQ, the agency reported it does not terminate an investigation solely because the source of the allegation recants the allegation.

Agency Policy AS-217 B Conducting Administrative Investigations, Section III (E.) (*pp. 4-5*) addresses additional considerations when investigating sexual abuse allegations. Section III (E.2.a) (*p. 4*) addresses not terminating an investigation solely because the source of the allegation recants the allegation.

Agency staff interviewed reported an investigation is not terminated if the source of the allegation recants his/her allegation. The auditor interviewed the TCSO staff that are responsible for conducting criminal investigations. The TCSO staff reported they would continue the investigation and submit a report to the DA.

**115.371(e).**

Agency staff interviewed reported when they discover evidence that a prosecutable crime may have taken place, the investigation is shut down and the General Counsel takes over. The first step is to let TCSO know and the compelled interviews are done by TCSO. A review of both investigative files reflected the cases involved resident-on-resident incidents. The auditor interviewed the TCSO staff that are responsible for conducting criminal investigations. The TCSO staff reported not being familiar with administrative investigations as they would only handle criminal investigations.

**115.371(f).**

Agency staff interviewed reported they trust everyone, even if they have cried wolf 10 times before and this is the eleventh report. It is still treated the same. They treat all the same even if initial or numerous cry wolf allegations. Staff reported during the investigation, they will find out more. Staff reported they would never require a resident who alleges sexual abuse to submit to a polygraph examination or truth telling device as a condition for proceeding with an investigation. The auditor interviewed the TCSO staff that are responsible for conducting criminal investigations. The TCSO staff reported they do not judge the credibility of the alleged victim, suspect, or witness; they would gather all statements and send them to the DA. Staff also reported they cannot require a resident who alleges sexual abuse to submit to a polygraph examination or truth telling device as a condition for proceeding with an investigation. A resident who had reported a sexual abuse incident reported the facility did not require him to take a polygraph test about what happened to him.

**115.371(g).**

To determine whether staff actions or failures to act contributed to the sexual abuse, staff interviewed reported they interview other staff, review policies and procedures and operating procedures, and an incident review is conducted. The incident review meeting is attended by shift supervisors, division managers, and the mental health team and is conducted to determine if staff misconduct or failure to act occurred. Staff reported administrative investigations are documented in written reports and the information in the reports includes the following: notification to TJJD; when investigation was assigned; who was interviewed; collection of staff/unit roster; victim, witness and perpetrator statements; incident reports; summary of interviews; conclusion based on the investigator's opinion; and points of agreement/disagreement based on the collection of the evidence and information. The auditor interviewed the TCSO staff that are responsible for conducting criminal investigations. The TCSO staff reported not being familiar with administrative investigations as they would only handle criminal investigations.

A review of both investigative files reflected investigators considered staff assignments, records of behaviors/events, and serious incidents reports. Staff also recorded the physical and testimonial evidence used to arrive at their findings.

**115.371(h).**

Agency staff interviewed reported the facility does not conduct criminal investigations. They would assign a report number and have emails between the agency and TCSO. Staff reported they have never seen a TCSO investigative report. The auditor interviewed the TCSO staff that are responsible for conducting criminal investigations. The TCSO staff reported reports are documented. The case is logged into the system, the report is written, reviewed, supplemental reports included, and sent to the DA unless there is insufficient evidence.

**115.371(i).**

In the PAQ, the agency reported substantiated allegations of conduct that appear to be criminal are referred for prosecution. The agency reported there were two substantiated allegations of conduct that appeared to be criminal that were referred for prosecution since the last PREA audit.

Agency staff interviewed reported any sexual abuse and sexual harassment investigation is referred to TCSO, and they trust the TCSO to refer the case for prosecution. Staff reported the TCSO officer assigned to the facility is very thorough and will make the facility investigators secure additional information if needed. The auditor interviewed the TCSO staff that are responsible for conducting criminal investigations. The TCSO staff reported they refer the case for prosecution as soon as they are done with the investigation.

In the Memo – 115.371, the agency reported both cases were referred to law enforcement and neither resulted in the filing of criminal charges. A review of the investigative files reflected no criminal charges were filed.

**115.371(j).**

In the PAQ, the agency reported it retains all written reports referenced pertaining to the administrative or criminal investigation of alleged sexual abuse or sexual harassment for as long as the alleged abuser is incarcerated or employed by the agency, plus five years.

Agency Policy AS-906 Incident Reviews and Data Collection, Section II (B.2.e) (p. 4) addresses sexual abuse data collection and retention. Agency Policy AS-217 Administrative Investigations, Section III (I) (p. 4) addresses maintaining investigation reports in perpetuity.

The auditor reviewed two investigative files, which reflected two different allegations of youth on youth abusive sexual contact.

**115.371(k).**

Agency Policy AS-901 Reporting of Child Abuse, Neglect, and Exploitation, Section II (pp. 1-2) addresses

Agency staff interviewed reported if a staff member alleged to have committed sexual abuse or sexual harassment were to terminate their employment prior to the completion of the investigation the agency would still proceed with the investigation. If criminal, it would be referred to the TCSO and they would proceed with the investigation. Staff reported it does not matter; they would still continue with the investigation. The auditor interviewed the TCSO staff that are responsible for conducting criminal investigations. The TCSO staff reported staff terminating employment prior to the completion of the investigation would not change the criminal investigation and would still proceed. Staff reported they do not work for the agency; they work for the Sheriff's Office.

**115.371(l).**

Auditor is not required to audit this provision.

**115.371(m).**

Agency staff interviewed reported when an outside agency investigates an incident of sexual abuse in their facility, they provide the information: incident report, staff roster. Staff reported they would be very transparent and would make things available. They would grant access to the residents within reason and staff would be made available. If staff needed to be interviewed are not at the facility, they would be asked to come in. To stay informed on the progress of an investigation conducted by an outside agency, staff reported investigators would stay in contact with outside agency investigators,

which is usually TJJD. If the outside agency is TCSO, they would stay in contact with TCSO Deputy assigned to the facility. The General Counsel tracks all the data regarding pending investigations and dispositions. The auditor interviewed the TCSO staff that are responsible for conducting criminal investigations. The TCSO staff reported the agency would wait for their results. They would ask that any new information that is learned be forwarded to the TCSO if the agency feels it is relevant. Staff reported if they were to be contacted on a PREA related investigation, they would get the TCSO's cooperation.

**Corrective Action:**

1. The auditor recommends no corrective action.

**Standard 115.372: Evidentiary standard for administrative investigations**

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

**115.372 (a)**

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

**Auditor Overall Compliance Determination**

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
  - b. AS-217 Administrative Investigations (*revised 12/1/16*)
  - c. AS-217 B Conducting Administrative Investigations (*revised 12/1/16*)
2. Interviews:
  - a. Investigative Staff

## Findings (By Provision):

### 115.372(a).

In the PAQ, the agency reported it does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated

Agency Policy AS-217 Administrative Investigations, Section II (A) (p. 1) defines the term Founded, to include the required preponderance of the evidence standard and states, "For sexual abuse or sexual harassment investigations involving juveniles, founded allegations are "substantiated allegations as defined in 28 C.F.R. Part 115." Agency Policy AS-217 B Conducting Administrative Investigations, Section II (A) (p. 1) requires the use of the same standard.

Staff interviewed reported the standard of the evidence required to substantiate allegations of sexual abuse or sexual harassment is 51%, preponderance of the evidence. A review of both investigative files reflects each investigator outlined their summary of findings, which included the information that supports the findings.

### Corrective Action:

1. The auditor recommends no corrective action.

## Standard 115.373: Reporting to residents

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

#### 115.373 (a)

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

#### 115.373 (b)

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

#### 115.373 (c)

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

resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility?  Yes  No

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

#### 115.373 (d)

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

#### 115.373 (e)

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

#### 115.373 (f)

- Auditor is not required to audit this provision.

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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

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

**The following evidence was analyzed in making the compliance determination:**

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
  - b. Juvenile Letter – Investigative Outcome Template
  - c. PREA Notification Memo (dated 8/23/18)
  - d. Memo – 115.373 (dated 8/23/18)
  - e. AS-904 Corrective Action and Notifications (revised 12/1/16)
  - f. Resident File
2. Interviews:
  - a. Superintendent
  - b. Investigative Staff
  - c. Resident who Reported a Sexual Abuse

**Findings (By Provision):**

**115.373(a).**

In the PAQ, the agency reported it has a policy requiring that any resident who makes an allegation that he or she suffered sexual abuse in an agency facility, the resident is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation. The agency reported there were two criminal and/or administrative investigations of alleged resident sexual abuse that were completed by the agency in the past 12 months. Of the alleged sexual abuse investigation, that were completed in the past 12 months, the agency reported one resident was notified of the results of the investigation.

In the PREA Notification Memo to the PREA auditor, the agency reported the PREA allegation concluded in a finding of “FOUNDED,” and the findings of the investigation were not reported to the resident prior to the resident’s departure. Agency Policy AS-904 Corrective Action and Notifications, Section III (F.1.a) (p. 4) addresses the notification of the findings of the investigation requirement.

The agency has prepared a standardized “Juvenile Letter – Investigative Outcome” template that is used by staff to inform the resident of the findings of the investigation. Staff interviewed reported the resident is notified of the outcome of the investigation. Staff added that the General Counsel has created a form that they give the resident.

**115.373(b).**

In the PAQ, the agency reported if an outside entity conducts such investigations, the agency requests the relevant information from the investigative entity in order to inform the resident of the outcome of the investigation. The agency reported there were no investigations of alleged resident sexual abuse in the facility that were completed by an outside agency in the past 12 months. Agency Policy AS-904 Corrective Action and Notifications, Section III (B.4) (p. 2) addresses contact with outside investigative agencies to monitor the status of the investigation.

**115.373(c).**

In the PAQ, the agency reported following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, the agency subsequently informs the resident whenever: The staff member is no longer posted within the resident's unit; The staff member is no longer employed at the facility; The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility; or The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility. The agency reported there have been no substantiated or unsubstantiated complaints of sexual abuse committed by a staff member against a resident in the past 12 months. Agency Policy AS-904 Corrective Action and Notifications, Section III (F.1.c) (p. 4) addresses the notification requirements, when the allegation involves staff. The policy addresses all four elements required by this provision of this standard.

**115.373(d).**

In the PAQ, the agency reported following a resident's allegation that he or she has been sexually abused by another resident, the agency subsequently informs the alleged victim whenever: the agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or the agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility.

Agency Policy AS-904 Corrective Action and Notifications, Section III (F.1.d) (p. 4-) addresses the notification requirements, when the allegation involves residents. The policy addresses both elements required by this provision of this standard. A resident who had reported a sexual abuse incident reported being told of the outcome of the investigation and that staff had him sign a paper.

**115.373(e).**

In the PAQ, the agency reported it has a policy that all such notifications or attempted notifications are documented. The agency reported there was one notification provided to a resident in the past 12 months, and that the notification was documented.

Agency Policy AS-904 Corrective Action and Notifications, Section III (F.4) (p. 5) requires notifications will be documented. A review of the resident's file reflected the notification was provided to the resident and documented. The documentation reflects the staff and resident's signatures.

**115.373(f).**

Auditor is not required to audit this provision.

**Corrective Action:**

1. The auditor recommends no corrective action.

## DISCIPLINE

### Standard 115.376: Disciplinary sanctions for staff

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

### 115.376 (a)

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

### 115.376 (b)

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

### 115.376 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories?  Yes  No

### 115.376 (d)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

### The following evidence was analyzed in making the compliance determination:

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)

- b. Memo – 115.376 (*dated 8/31/18*)
- c. AS-904 Corrective Action and Notifications (*revised 12/1/16*)

### **Findings (By Provision):**

#### **115.376(a).**

In the PAQ, the agency reported staff is subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

Agency Policy AS-904 Corrective Action and Notifications, Section III (D) (*p. 3*) addresses disciplinary actions for staff in which an administrative investigation indicates that a staff member sexually abused or sexually harassed a juvenile. The policy also addresses actions that may be taken against contractors and volunteers. Section III (D.1.a) (*p. 3*) states, “The presumptive disciplinary sanction for staff found to have engaged in sexual abuse is termination.”

#### **115.376(b).**

In the PAQ, the agency reported there were no staff from the facility who have violated agency sexual abuse or sexual harassment policies in the past 12 months.

In the Memo – 115.376 to the PREA auditor, the agency reported, “There were no cases of alleged sexual abuse or sexual harassment by a staff member, contractor, intern or volunteer from October 30, 2017 to present.”

#### **115.376(c).**

In the PAQ, the agency reported the disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are commensurate with the nature and circumstances of the acts committed, the staff member’s disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. The agency reported there were no staff from the facility who have been disciplined for violation of agency sexual abuse or sexual harassment policies in the past 12 months.

In the Memo – 115.376 to the PREA auditor, the agency reported, “There were no cases of alleged sexual abuse or sexual harassment by a staff member, contractor, intern or volunteer from October 30, 2017 to present.”

Agency Policy AS-904 Corrective Action and Notifications, Section III (D.1.b) (*p. 3*) states, “Disciplinary sanctions will be commensurate with the nature and circumstances of the acts committed, the staff member’s disciplinary history, and the sanctions imposed for comparable misconduct.”

#### **115.376(d).**

In the PAQ, the agency reported all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies and relevant licensing bodies. The agency reported there were no staff from the facility who have been reported to law enforcement agencies or relevant licensing bodies for violating agency sexual abuse or sexual harassment policies in the past 12 months.

In the Memo – 115.376 to the PREA auditor, the agency reported, “There were no cases of alleged sexual abuse or sexual harassment by a staff member, contractor, intern or volunteer from October 30, 2017 to present.”

Agency Policy AS-904 Corrective Action and Notifications, Section III (D.1.b) (p. 3) states, “The Chief or designee will contact the staff member’s licensing and / or certification agency regarding all founded violations of the Department’s sexual abuse or sexual harassment policies. Notifications will include terminations and resignations by staff members who would have been terminated if they had not resigned.”

**Corrective Action:**

- 1. The auditor recommends no corrective action.

**Standard 115.377: Corrective action for contractors and volunteers**

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

**115.377 (a)**

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents?  Yes  No
- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)?  Yes  No
- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies?  Yes  No

**115.377 (b)**

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents?  Yes  No

**Auditor Overall Compliance Determination**

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

**Instructions for Overall Compliance Determination Narrative**

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

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

**The following evidence was analyzed in making the compliance determination:**

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
  - b. Memo – 115.377 (dated 8/31/18)
  - c. AS-904 Corrective Action and Notifications (revised 12/1/16)
2. Interviews:
  - a. Superintendent

**Findings (By Provision):**

**115.377(a).**

In the PAQ, the agency reported agency policy requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies and relevant licensing bodies, unless the activity was clearly not criminal. Agency policy also requires that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents. The agency reported there were no contractors or volunteers who have been reported to law enforcement agencies or relevant licensing bodies for engaging in sexual abuse of residents in the past 12 months.

In the Memo – 115.377 to the PREA auditor, the agency reported, “There were no cases of alleged sexual abuse or sexual harassment by a staff member, contractor, intern or volunteer from October 30, 2017 to present.”

Agency Policy AS-904 Corrective Action and Notifications, Section III (D.1.b) (p. 3) states, “The Chief or designee will contact the staff member’s licensing and / or certification agency regarding all founded violations of the Department’s sexual abuse or sexual harassment policies. Notifications will include terminations and resignations by staff members who would have been terminated if they had not resigned.” Section II (B) (p. 1) defines staff as, “A person hired to a position in the Department, or an intern, volunteer, contracted program services staff or other individuals working under the auspices of the Department.”

**115.377(b).**

In the PAQ, the agency reported it takes appropriate remedial measures and consider whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

Agency Policy AS-904 Corrective Action and Notifications, Section III (D.4) (p. 3) addresses the prohibition of contractors and volunteers from further contact with any individual under the supervision of the Department.

Staff interviewed reported they would suspend access to a contractor or volunteer immediately until the completion of the investigation.

**Corrective Action:**

1. The auditor recommends no corrective action.

## Standard 115.378: Interventions and disciplinary sanctions for residents

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

### 115.378 (a)

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, may residents be subject to disciplinary sanctions only pursuant to a formal disciplinary process?  
 Yes  No

### 115.378 (b)

- Are disciplinary sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories?  Yes  No
- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise?  Yes  No
- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services?  Yes  No
- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician?  Yes  No
- In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible?  Yes  No

### 115.378 (c)

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior?  Yes  No

### 115.378 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions?  Yes  No
- If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education?  Yes  No

### 115.378 (e)

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

### 115.378 (f)

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

### 115.378 (g)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

### The following evidence was analyzed in making the compliance determination:

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
  - b. Memo – 115.378 (dated 8/29/18)
  - c. AS-904 Corrective Action and Notifications (revised 12/1/16)
  - d. RS-9.40 Isolation, Seclusion and Separation (effective 2/10/17)
2. Interviews:
  - a. Superintendent
  - b. Medical and Mental Health Staff

## Findings (By Provision):

### 115.378(a).

In the PAQ, the agency reported residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse. The agency reported there were no administrative findings that a resident engaged in resident-on-resident sexual abuse or criminal findings of guilt for resident-on-resident sexual abuse in the past 12 months.

Agency Policy AS-904 Corrective Action and Notifications, Section III (E) (*pp. 3-4*) prohibits juvenile-on-juvenile sexual conduct and addresses the program and facility's discipline plan. Agency Policy RS-9.40 Isolation, Seclusion and Separation, Section III (C.1) (*p. 3*) addresses room restriction and disciplinary restriction and allowing the resident to rejoin the program as soon as the behavior is corrected. In the Memo – 115.378 to the PREA auditor, the agency reported, "There have been two different allegations of youth-on-youth abusive sexual contact in Residential Services during audit period of November 30, 2017 to present. Neither case resulted in disciplinary confinement based on the abusive sexual contact."

### 115.378(b).

In the PAQ, the agency reported, in the event a disciplinary sanction results in the isolation of a resident, the agency policy requires that residents have access to daily large-muscle exercise, any legally required educational programming or special education services, daily visits from a medical or mental health care clinician, and access to other programs and work opportunities to the extent possible. The agency reported there were no residents placed in isolation as a disciplinary sanction for resident-on resident sexual abuse in the past 12 months.

Agency Policy AS-904 Corrective Action and Notifications, Section III (E.6) (*p. 4*) prohibits the denial of access to exercise, medical or mental health, education programming or special education services, or other programs or work opportunities. Agency Policy RS-9.40 Isolation, Seclusion and Separation, Section III (C.1.a) (*p. 3*) states, Room Restriction / Disciplinary Restriction: Room restriction / disciplinary restriction may be utilized to briefly restrict a resident to a room in order to allow the resident the opportunity to self-correct inappropriate behavior, prevent potentially disruptive behavior or when the resident's behavior could be deemed dangerous to themselves or others. a. Residents will be allowed to rejoin programming as soon as the potentially disruptive behavior is corrected."

In the Memo – 115.378 to the PREA auditor, the agency reported, "There have been two different allegations of youth-on-youth abusive sexual contact in Residential Services during audit period of November 30, 2017 to present. Neither case resulted in disciplinary confinement based on the abusive sexual contact." Staff interviewed reported if it is a major rule violation, privileges are suspended. Staff determine if rule a violation is true or false and try to determine what and how to stop it from happening in the future again.

### 115.378(c).

Staff interviewed reported if it is a major rule violation, privileges are suspended. Staff determine if rule violation is true or false and try to determine what and how to stop it from happening in the future again.

### 115.378(d).

In the PAQ, the agency reported it offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, but the facility does not consider whether to require the offending resident to participate in such interventions as a condition of access to

any rewards-based behavior management system or other behavior-based incentives. The agency reported access to general programming or education is not conditional on participation in such interventions. Agency Policy AS-904 Corrective Action and Notifications, Section III (E.5) (p. 4) addresses therapy, counseling or other interventions to address resident behavior.

Staff interviewed reported it offers therapy, counseling, or other intervention services designed to address and correct the underlying reasons or motivations for sexual abuse to the offending resident. Staff reported they do not require a resident's participation as a condition of access to any rewards-based behavior management system, programming or education. Staff reported the intent is to provide services to the offending residents that can be woven into the treatment that the resident is receiving. The treatment team works on creating a safety plan on the conduct of the resident's behavior and how some housing decisions are being made.

**115.378(e).**

In the PAQ, the agency reported it disciplines residents for sexual conduct with staff only upon a finding that the staff member did not consent to such contact.

**115.378(f).**

In the PAQ, the agency reported it prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation.

Agency Policy AS-904 Corrective Action and Notifications, Section III (C) (p. 4) addresses reports made in good faith would not constitute false reporting.

**115.378(g).**

In the PAQ, the agency reported it prohibits all sexual activity between residents. The agency reported it disciplines residents for such activity, when the agency deems such activity to constitute sexual abuse only if it determines that the activity is coerced.

**Corrective Action:**

1. The auditor recommends no corrective action.

## MEDICAL AND MENTAL CARE

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

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

**115.381 (a)**

- If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening?  Yes  No

### 115.381 (b)

- If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening?  Yes  No

### 115.381 (c)

- Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law?  Yes  No

### 115.381 (d)

- Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18?  Yes  No

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

### The following evidence was analyzed in making the compliance determination:

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
  - b. Memo – 115.381 (*dated 8/29/18*)
  - c. AS-905 Services for Victims of Sexual Abuse (*revised 2/19/16*)
  - d. 8-DS-5 Access to Mental Health Care (*revised 6/8/15*)
  - e. Health Assessment Screening Form (*revised 1/29/16*)
  - f. Physician's Telephone Orders Form

- g. Counselor Referral Form
- h. Consent for Disclosure of ANE Form
- i. Resident Files

2. Interviews:

- a. Staff Responsible for Risk Screening
- b. Medical and Mental Health Staff
- c. Residents who Disclose Sexual Victimization at Risk Screening

3. Onsite Review:

- a. Medical
- b. Housing Units

**Findings (By Provision):**

**115.381(a).**

In the PAQ, the agency reported all residents who have disclosed any prior sexual victimization, during a screening are offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. Staff reported 100% of the residents who disclosed prior sexual victimization, during screening were offered a follow-up meeting with a medical or mental health practitioner. The agency also reported medical and mental health staff maintain secondary materials documenting the services provided.

In Memo – 115.381 to the PREA auditor, the department outlines the screening process, including the resident’s right to access nursing and counseling staff regardless of their disclosure during the screening process. Residents undergo the Massachusetts Youth Screening Instrument (MAYSI-2) during intake, and are required to have a psychological and/or a psychiatric evaluation within 365 days of admission. All residents in the ISC have a treatment and counseling staff assigned to their unit.

Agency Policy AS-905 Services for Victims of Sexual Abuse, Section III (A.1) (*pp. 1*) requires intake staff offer follow-up services to juveniles who disclose prior victimization as soon as possible, but no later than 14 days after the screening. Agency Policy 8-DS-5 Access to Mental Health Care, Section III (C) (*p. 2*) requires juveniles be screened for mental health issues prior to admission to facilities and that nursing and intake staff will make referrals for additional non-emergency assessments and/or follow-up services based on the available information. The screening process includes gathering information regarding evidence of abuse and trauma. Section III (D) (*p. 3*) requires juveniles participate in a psychological evaluation prior to admission to the Department’s post-adjudication secure facility. The Health Assessment Screening Form (*p. 3*) inquires on any evidence or allegations of sexual abuse. The Counselor Referral Form indicates the nature of request and referral source.

Staff interviewed reported they would immediately offer a follow-up meeting with a medical and/or medical health practitioner if a screening indicates a resident has experienced prior sexual victimization. At the time of the audit, the agency reported there were no residents who disclosed sexual victimization during the risk screening currently being housed at the facility. The auditor requested that if a resident disclosed sexual victimization during the risk screening was admitted during the onsite audit phase, that facility staff advise the auditor of the admission. The auditor randomly asked staff if they were aware of any residents who disclosed sexual victimization during the risk screening that were currently placed at the facility, to which they responded no.

A review of 15 resident files indicated one resident that was screened for prior sexual victimization and also previously perpetrated sexual abuse. The records reflect mental health staff saw the resident four days after the intake screening process. While meeting with mental health staff, the resident disclosed prior sexual victimization at a facility the resident had been previously detained. This allegation was not disclosed during the initial intake screening process. Mental health staff initiated the proper reporting protocols. A review of the medical records reflected medical staff saw the resident 11 days after the reported allegation and also provided subsequent medical consultation.

**115.381(b).**

In the PAQ, the agency reported all residents who have ever previously perpetrated sexual abuse are offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening. Staff reported 100% of the residents who previously perpetrated sexual abuse, as indicated during screening, were offered a follow-up meeting with a mental health practitioner. The agency also reported mental health staff maintain secondary materials documenting the services provided.

In Memo – 115.381 to the PREA auditor, the department outlines the screening process, including the resident's right to access nursing and counseling staff regardless of their disclosure during the screening process. Residents undergo the Massachusetts Youth Screening Instrument (MAYSI-2) during intake, and are required to have a psychological and/or a psychiatric evaluation within 365 days of admission. All residents in the ISC have a treatment and counseling staff assigned to their unit. Agency Policy AS-905 Services for Victims of Sexual Abuse, Section III (A.1) (p.1)

Staff interviewed reported they would immediately offer a follow-up meeting with a mental health practitioner if a screening indicates a resident has previously perpetrated sexual abuse. Staff added this could involve moving the resident to a different unit or placement decision would be made.

A review of 15 resident files indicated one resident that was screened for prior sexual victimization and also previously perpetrated sexual abuse. The records reflect mental health staff saw the resident four days after the intake screening process. While meeting with mental health staff, the resident disclosed prior sexual victimization at a facility the resident had been previously detained. This allegation was not disclosed during the initial intake screening process. Mental health staff initiated the proper reporting protocols. A review of the medical records reflected medical staff saw the resident 11 days after the reported allegation and also provided subsequent medical consultation.

**115.381(c).**

In the PAQ, the agency reported information related to sexual victimization or abusiveness that occurred in an institutional setting is strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law.

During the onsite review, the auditor visited the medical unit and informally interviewed medical staff. The staff interviewed reported receiving PREA related training. Staff reported all medical records are maintained in the medical unit. Medical files are initiated while the resident is in the pre-adjudication facility and transferred to the post-adjudication facility's medical unit, where they are maintained, when the resident is transferred. The medical unit contains one exam room and one dental exam room. A waiting area is utilized as needed. Medical services are available 24/7; the nighttime nurse is stationed at the pre-adjudication facility and provides coverage for both pre-adjudication and post-adjudication facilities. Staff interviewed reported residents can see medical staff privately, without an officer present. The medical facility is not equipped to conduct forensic exams, and residents who reported a sexual

abuse allegation would be triaged and provided first aid and arrangements would be made to transport the resident to the hospital. Staff reported TJJJ and the police would be notified.

A review of 15 resident files indicated one resident that was screened for prior sexual victimization and also previously perpetrated sexual abuse. The records reflect mental health staff saw the resident four days after the intake screening process. While meeting with mental health staff, the resident disclosed prior sexual victimization at a facility the resident had been previously detained. This allegation was not disclosed during the initial intake screening process. Mental health staff initiated the proper reporting protocols. A review of the medical records reflected medical staff saw the resident 11 days after the reported allegation and also provided subsequent medical consultation.

**115.381(d).**

In the PAQ, the agency reported medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18.

In Memo – 115.381 to the PREA auditor, the department reports, “If an individual turns 18 while in the custody of the facility, he or she will sign their own consent forms. All allegations of abuse, neglect and exploitation, to include sexual abuse and sexual harassment (ANE), will require the staff to obtain consent for reporting purposes. From October 31, 2017 to August 29, 2018, there have been no instances in which a resident over the age of 18 has made an ANE allegation.”

Agency Policy AS-905 Services for Victims of Sexual Abuse, Section III (p. 2), addresses the requirement that staff obtain informed consent from individuals over 18 years of age in accordance with this provision.

One of the two staff interviewed reported they obtain consent from the residents before reporting prior sexual victimization that did not occur in an institutional setting. Staff reported they do not wait for them to give permission or consent (for minors); they are not actually asking them for permission, but actually informing them so that they know staff are mandatory reporters.

A review of 15 resident files indicated one resident over the age of 18 who reported sexual victimization in another institution. Mental health staff was not required to secure a signed consent form due to the reported alleged sexual abuse having been reported to have occurred at another institution.

**Corrective Action:**

1. The auditor recommends no corrective action.

**Standard 115.382: Access to emergency medical and mental health services**

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

**115.382 (a)**

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by

medical and mental health practitioners according to their professional judgment?  Yes  No

#### 115.382 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362?  Yes  No
- Do staff first responders immediately notify the appropriate medical and mental health practitioners?  Yes  No

#### 115.382 (c)

- Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate?  Yes  No

#### 115.382 (d)

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

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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

#### The following evidence was analyzed in making the compliance determination:

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
  - b. AS-905 Services for Victims of Sexual Abuse (*revised 2/19/16*)
  - c. 8-DS-5 Access to Mental Health Care (*revised 6/8/15*)

- d. Travis County Juvenile Probation Health Services (TCJPHS) – Physician’s Progress and Health Care Notes
- e. TCJPHS – Health Care Notes
- f. TCJPD Care Plan (Medical)
- g. Sick Call Form
- h. Initial Progress Note – Intermediate Sanctions Center (ISC) (Mental Health)
- i. Individual Counseling Progress Notes ISC
- j. Counselor Daily Contact Log
- k. Data, Assessment, and Plan (DAP) Notes

2. Interviews:

- a. Medical and Mental Health Staff
- b. Security Staff and Non-Security Staff First Responders
- c. Residents who Reported a Sexual Abuse

3. Onsite Review:

- a. Medical Unit

**Findings (By Provision):**

**115.382(a).**

In the PAQ, the agency reported resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment. The agency also reported medical and mental health staff maintain secondary materials documenting the timelines of emergency medical treatment and crisis intervention services provided.

Agency Policy AS-905 Services for Victims of Sexual Abuse, Section III (A.3) (p. 2) provides for medical and mental health staff making the determinations on what testing and treatment services will be made. Section III (B-C) (p. 2-3) address medical, mental health and crisis intervention counseling services that will be made available to juvenile victims of sexual abuse.

The medical and mental health forms used by medical and mental health staff document the initial assessments and follow-up treatment/services that would be provided by medical and mental health practitioners.

During the onsite review, the auditor visited the medical unit and informally interviewed medical staff. The staff interviewed reported receiving PREA related training. Staff reported all medical records are maintained in the medical unit. Medical files are initiated while the resident is in the pre-adjudication facility and transferred to the post-adjudication facility’s medical unit, where they are maintained, when the resident is transferred. The medical unit contains one exam room and one dental exam room. A waiting area is utilized as needed. Medical services are available 24/7; the nighttime nurse is stationed at the pre-adjudication facility and provides coverage for both pre-adjudication and post-adjudication facilities. Staff interviewed reported residents can see medical staff privately, without an officer present. The medical facility is not equipped to conduct forensic exams, and residents who reported a sexual abuse allegation would be triaged and provided first aid and arrangements would be made to transport the resident to the hospital. Staff reported TJJ and the police would be notified.

Staff interviewed reported residents receive timely and unimpeded access to emergency medical treatment and crisis intervention services. Staff reported they would respond immediately. Mental

health staff reported in the event of after hour incidents, they have a crisis “beeper” for 24/7 crisis response. The auditor noted medical services are accessible 24/7. Staff reported that the nature and scope of the services are determined according to their professional judgment. The auditor interviewed a resident who had reported a sexual abuse incident. The resident reported being seen by medical “right away.”

**115.382(b).**

The auditor interviewed staff who acted as a first responder. Staff reported the incident did not involve a sexual abuse allegation. Staff reported once she was aware of the allegation, it was reported to the supervisor and the resident’s counselor was contacted. Staff reported when made aware of an allegation, they report it to the supervisor, medical, CPS, TJJJ and the police. The victim would be taken to medical right away. Staff would write an incident report.

**115.382(c).**

In the PAQ, the agency reported resident victims of sexual abuse are offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate.

Agency Policy AS-905 Services for Victims of Sexual Abuse, Section III (B) (p. 2-3) addresses medical services that will be made available to juvenile victims of sexual abuse, which includes transportation to a hospital, clinic, or emergency room.

Staff interviewed reported victims of sexual abuse would be offered timely information about access to emergency contraception and sexually transmitted infection prophylaxis. The auditor interviewed a resident who had reported a sexual abuse incident. The resident reported no other medical services were provided as the incident involved being “touched by a peer.”

**115.382(d).**

In the PAQ, the agency reported 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.

Agency Policy AS-905 Services for Victims of Sexual Abuse, Section III (B.2 and C.3) (pp. 2-3) addresses services being provided and the cost of the services will not be assessed to the victim or his or her family whether or not the victim names the abuser and/or cooperates with any administrative or criminal investigation.

**Corrective Action:**

1. The auditor recommends no corrective action.

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

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

**115.383 (a)**

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility?  Yes  No

#### 115.383 (b)

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

#### 115.383 (c)

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

#### 115.383 (d)

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

#### 115.383 (e)

- If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.)  Yes  No  NA

#### 115.383 (f)

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

#### 115.383 (g)

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

#### 115.383 (h)

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

### Auditor Overall Compliance Determination

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

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

### Instructions for Overall Compliance Determination Narrative

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

### The following evidence was analyzed in making the compliance determination:

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
  - b. AS-905 Services for Victims of Sexual Abuse (*revised 2/19/16*)
2. Interviews:
  - a. Medical and Mental Health Staff
  - b. Residents who Reported a Sexual Abuse
3. Onsite Review:
  - a. Medical Unit

### Findings (By Provision):

#### 115.383(a).

In the PAQ, the agency reported it offers medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in the juvenile facility. Agency Policy AS-905 Services for Victims of Sexual Abuse, Section III (B, C) (*pp. 2-3*) addresses medical and mental health services, including crisis intervention counseling services, will be made available to juvenile victims of sexual abuse.

During the onsite review, the auditor visited the medical unit and informally interviewed medical staff. The staff interviewed reported medical services are available 24/7; the nighttime nurse is stationed at the pre-adjudication facility and provides coverage for both pre-adjudication and post-adjudication facilities. Staff interviewed reported residents can see medical staff privately, without an officer present. The medical facility is not equipped to conduct forensic exams, and residents who reported a sexual abuse allegation would be triaged and provided first aid and arrangements would be made to transport the resident to the hospital. The medical unit contains one exam room and one dental exam room. A waiting area is utilized as needed. Mental health staff reported, in the event of after hour incidents, they have a crisis "beeper" for 24/7 crisis response.

#### 115.383(b).

Medical staff interviewed reported they will interview the resident and notify their supervisor, CPS, law enforcement, and SafePlace so they can get the prophylaxis for HIV/STDs and get treated. Staff reported residents are always helped. Mental health staff interviewed reported they would do an

extensive evaluation throughout the time the resident is at the facility, which includes the following assessments: MAYSI, Child Sex Trafficking, Child Trauma Check, and psychological evaluation. Prior to being ordered placed and after, they do an additional psychosocial assessment. Staff reported they prepare a customized individual treatment plan and are constantly assessing, reassessing, and reappraising the resident's treatment plan. Staff added the resident has a voice in their treatment plan.

The auditor interviewed a resident who had reported a sexual abuse incident. The resident reported being seen by medical "right away." The resident reported he spoke with a nurse who was making sure he was "alright and safe."

**115.383(c).**

Agency Policy AS-905 Services for Victims of Sexual Abuse, Section III (A.4) (p. 2) states, "All medical and mental health services and treatments will be consistent with the community level of care.

Staff interviewed reported the medical and mental health services provided are consistent with the community level of care. Mental health staff reported they meet or exceed the community level of care and everyone is licensed and answer to their licensing board as well as meet TJJD, PREA and County Standards.

**115.383(d).**

In the PAQ, the agency reported female victims of sexually abusive vaginal penetration while incarcerated are offered pregnancy tests. Agency Policy AS-905 Services for Victims of Sexual Abuse, Section III (B.3.d) (p. 3) requires that pregnancy tests will be offered to victims of sexually abusive vaginal penetration.

The facility reported and the auditor noted there were no female residents who had reported a sexual abuse incident involving vaginal penetration, therefore no resident was interviewed specific to this provision.

**115.383(e).**

In the PAQ, the agency reported if pregnancy results from sexual abuse while incarcerated, victims receive timely and comprehensive information about, and timely access to, all lawful pregnancy-related medical services. Agency Policy AS-905 Services for Victims of Sexual Abuse, Section III (B.3.d) (p. 3) states, "If pregnancy results, the victim will be provided timely and comprehensive information about and timely access to all lawful pregnancy-related medical services."

Staff interviewed reported if a pregnancy were to result from a sexual abuse incident while at the facility, the victims would be given timely information and access to all lawful pregnancy-related services. Staff added information and services would be provided immediately. The facility reported and the auditor noted there were no female residents who had reported a sexual abuse incident involving vaginal penetration, therefore no resident was interviewed specific to this provision.

**115.383(f).**

In the PAQ, the agency reported resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate. Agency Policy AS-905 Services for Victims of Sexual Abuse, Section III (B.3.c) (p. 3) states, "Victims are entitled to receive testing for sexually transmitted infections (STIs) and any subsequent treatment." The auditor interviewed a resident who had reported a sexual abuse incident. The resident reported no other medical services were provided as the incident involved being "touched by a peer."

**115.383(g).**

In the PAQ, the agency reported 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. Agency Policy AS-905 Services for Victims of Sexual Abuse, Section III (B.2 and C.3) (pp. 2-3) addresses services being provided and the cost of the services will not be assessed to the victim or his or her family whether or not the victim names the abuser and/or cooperates with any administrative or criminal investigation. The auditor interviewed a resident who had reported a sexual abuse incident. The resident stated, “I don’t think we had to pay.”

**115.383(h).**

In the PAQ, the agency reported it attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners. Agency Policy AS-905 Services for Victims of Sexual Abuse, Section III (D.3.d.1) (p. 3) states, “The Department will attempt to conduct a mental health evaluation of all known juvenile abusers within 60 days of learning of the abuse history.”

Staff interviewed reported mental health evaluations and treatment are provided to each resident. Each resident has a treatment plan and a treatment team. Staff reported treatment would be woven in carefully for every resident facing a particular adjudication and they would work with the resident’s probation officer and attorney. They would consider due process and the other resident’s safety and incorporate this into the treatment plan. This would be done continuously and on an on-going basis. Each abuser would be assessed – psychological evaluation, psychosocial assessment, and Juvenile Sex Offender Assessment Protocol (JSOAP).

**Corrective Action:**

1. The auditor recommends no corrective action.

**DATA COLLECTION AND REVIEW**

**Standard 115.386: Sexual abuse incident reviews**

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

**115.386 (a)**

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded?  Yes  No

**115.386 (b)**

- Does such review ordinarily occur within 30 days of the conclusion of the investigation?  Yes  No

**115.386 (c)**

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners?  Yes  No

#### 115.386 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse?  Yes  No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility?  Yes  No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse?  Yes  No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts?  Yes  No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff?  Yes  No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager?  Yes  No

#### 115.386 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so?  Yes  No

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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

**The following evidence was analyzed in making the compliance determination:**

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
  - b. AS-906 Incident Reviews and Data Collection (*effective 2/6/15*)
  - c. Incident Reviews
2. Interviews:
  - a. Superintendent
  - b. PREA Compliance Manager
  - c. Incident Review Team

**Findings (By Provision):**

**115.386(a).**

In the PAQ, the agency reported it conducts a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded. The agency reported there were two administrative investigations of alleged sexual abuse completed at the facility in the past 12 months.

Agency Policy AS-906 Incident Reviews and Data Collection, Section I (*p. 1*), states, “The Department will evaluate incidents of sexual abuse and sexual harassment and collect incident-specific data regarding those allegations. Section II (*pp. 1-4*) addresses incident review procedures and data collection.

**115.386(b).**

In the PAQ, the agency reported such reviews ordinarily occur within 30 days of the conclusion of the investigation. The agency reported two administrative investigations of alleged sexual abuse were completed and followed by a sexual abuse incident review within 30 days.

Agency Policy AS-906 Incident Reviews and Data Collection, Section II (A.1) (*p. 1*) requires the review be conducted within 30 days of the conclusion of the investigation. A review of the incident review reports reflected both were completed within 13 days of the completion of the investigation.

**115.386(c).**

In the PAQ, the agency reported the review teams include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners.

Agency Policy AS-906 Incident Reviews and Data Collection, Section II (A.2) (*p. 1*) addresses the several disciplines to serve on the Sexual Abuse Review Team as well as facility administrators, supervisors, medical and/or mental health practitioners, line staff, investigators and the PREA Coordinator.

Staff interviewed reported the facility has an incident review includes the Division Management Team, Deputy Chief, Treatment/Counseling (Mental Health Services), and any staff that might be beneficial. A review of the incident review reports reflected both included teams made up of upper management staff and allowed for input from line supervisors, investigators, and mental health practitioners, as appropriate.

**115.386(d).**

In the PAQ, the agency reported it prepares a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager.

Agency Policy AS-906 Incident Reviews and Data Collection, Section II (A.3-4) (pp. 1-2) addresses all the required elements under this provision and the submission of the report to the CJPO.

Staff interviewed reported they take the information and identify if change in policy or staffing assignments are needed. They identify the type of population and what type of procedures to have. Staff reported they are looking forward to the new camera system for improvement in several areas. Staff reported the Compliance Unit reviews all data on a quarterly basis for the CJPO and the Judges. Trends or concerns are identified and the policies and procedures are modified if they can make things better to reduce incidents. Staff reported they review all PREA related incidents, which includes both sexual abuse and sexual harassment incidents. The team reviews the action steps that need to be completed, how they are related to the standards, and develop a process and plan ahead and decide how they will handle situations in the future. The Compliance Unit maintains all sexual abuse and sexual harassment reports. Staff reported each incident is individually reviewed for and considers whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or if it was motivated or otherwise caused by other group dynamics at the facility. Staff also assess whether physical barriers (beams, obstructions) and staff supervision. The chief investigator reads out loud the incident review report during the incident review meeting, which is conducted within 30 days. Staff reported this is often done for sexual harassment allegations as well. For sexual harassment incidents, the team looks for staff being aware of the incident; the goal is for these meetings to be very helpful to staff. Staff reported they assess the adequacy of staffing levels, depending on whether it is the Division Director, Division Manager, or Casework Manager, they would oversee to make sure staffing ratios are in order. Staff also reported monitoring technology could have been helpful in supervision related incidents. Currently, the agency relies on direct supervision.

**115.386(e).**

In the PAQ, the agency reported it implements the recommendations for improvement, or documents its reasons for not doing so.

Agency Policy AS-906 Incident Reviews and Data Collection, Section II (A.4.b-c) (p. 2) addresses the implementation of the recommendations and the reasons for not implementing the recommendations will be documented.

A review of the incident report reflected both were addressed from the PREA Compliance Managers (PCM) to the CJPO, through the General Counsel. One of the PREA Compliance Managers is the PCM for the pre-adjudication facility.

**Corrective Action:**

1. The auditor recommends no corrective action.

**Standard 115.387: Data collection**

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

**115.387 (a)**

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions?  Yes  No

**115.387 (b)**

- Does the agency aggregate the incident-based sexual abuse data at least annually?  Yes  No

**115.387 (c)**

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice?  Yes  No

**115.387 (d)**

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews?  Yes  No

**115.387 (e)**

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.)  Yes  No  NA

**115.387 (f)**

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.)  Yes  No  NA

**Auditor Overall Compliance Determination**

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

1. Documents:

- a. Pre-Audit Questionnaire (PAQ)
- b. AS-906 Incident Reviews and Data Collection (*effective 2/6/15*)
- c. Memo – 115.387
- d. 2018 Investigations – ANE/PREA (Pre-adjudication Facility)
- e. Aggregated Data
  - i. 4M Granbury Youth Services
  - ii. Cornell Corrections of Texas, Inc. (Gulf Coast Trade Center)
  - iii. Hector Garza Center
  - iv. Rockdale Regional Juvenile Justice
  - v. Hays County Juvenile Center
  - vi. The Oaks Brownwood – True Core
  - vii. Pegasus Schools, Inc.
  - viii. Victoria Regional
- f. Survey of Sexual Victimization (SSV-6), 2017 Report – Gardner-Betts Juvenile Justice Center Detention
- g. Survey of Sexual Victimization (SSV-6), 2017 Report – Meurer Intermediate Sanctions Center

**Findings (By Provision):**

**115.387(a).**

In the PAQ, the agency reported it collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. Agency Policy AS-906 Incident Reviews and Data Collection, Section II (B) (p. 3), addresses the collection of accurate, uniform data for every sexual abuse allegation, including sexual harassment allegations.

**115.387(b).**

In the PAQ, the agency reported it aggregates the incident-based sexual abuse data at least annually.

**115.387(c).**

In the PAQ, the agency reported the incident-based data includes, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence (SSV) conducted by the Department of Justice. Agency Policy AS-906 Incident Reviews and Data Collection, Section II (B.2) (p. 3), addresses the minimum required data to answer all the questions from the SSV.

The 2018 Investigations – ANE/PREA Activity Log demonstrated the facility tracks activity from the pre-adjudication facility. In Memo – 115.387, the agency reports, one of the functions of the Compliance Unit is to populate and maintain the investigation database. The database contains information on all allegations of abuse, neglect and exploitation as defined by the TJJD, which includes youth sexual conduct. All sexual abuse and sexual harassment investigations are entered into the database, which has sufficient information to answer the questions in the most recent SSV. The attachment to the memo is a screenshot of the TCJPD Investigation Database. The tabs on the screenshot include: General Information, TCJPD Internal Investigation Information; Law Enforcement Investigation Information; TJPC Investigation Information; and Personnel Information.

**115.387(d).**

In the PAQ, the agency reported it maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

Agency Policy AS-906 Incident Reviews and Data Collection, Section II (B.1) (p. 3), addresses data from all available documents, reports, files and incident reviews.

**115.387(e).**

In the PAQ, the agency reported it obtains incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents.

The auditor requested and the agency secured the incident-based aggregated data from the following facilities it contracts with, which includes public facilities:

1. 4M Granbury Youth Services
2. Hector Garza Center
3. Rockdale Regional Juvenile Justice
4. Hays County Juvenile Center
5. The Oaks Brownwood – True Core
6. Pegasus Schools, Inc.
7. Victoria Regional
8. Cornell Corrections of Texas, Inc. (Gulf Coast Trade Center)

**115.387(f).**

In the PAQ, the agency reported it, upon request, provided all such data from the previous calendar year to the Department of Justice (DOJ) no later than June 30.

Agency Policy AS-906 Incident Reviews and Data Collection, Section II (B.3) (p. 3), addresses providing data to the DOJ upon request.

During the past three-year cycle, the DOJ requested data the data for both the detention and residential facilities. The agency responded and submitted the following reports:

1. Survey of Sexual Victimization (SSV-6), 2017 Report – Gardner-Betts Juvenile Justice Center Detention
2. Survey of Sexual Victimization (SSV-6), 2017 Report – Meurer Intermediate Sanctions Center

**Corrective Action:**

1. The agency secured the incident-based aggregated data from the facilities it contracts with for the confinement of its residents, including the public facilities.

**Standard 115.388: Data review for corrective action**

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

**115.388 (a)**

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas?  Yes  No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis?  
 Yes  No
- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole?  Yes  No

#### 115.388 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse  Yes  No

#### 115.388 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means?  Yes  No

#### 115.388 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility?  Yes  No

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

### The following evidence was analyzed in making the compliance determination:

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)

- b. AS-906 Incident Reviews and Data Collection (*effective 2/6/15*)
- c. 2017 TCJPD Annual Report, Findings and Action Plan

2. Interviews:

- a. Agency Head
- b. PREA Coordinator
- c. PREA Compliance Manager

**Findings (By Provision):**

**115.388(a).**

In the PAQ, the agency reported it reviews data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: identifying problem areas; taking corrective action on an ongoing basis; and preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole. Agency Policy AS-906 Incident Reviews and Data Collection, Section II (C) (p. 3) addresses data collection in order to improve the agencies effectiveness of its sexual abuse prevention, detection, response policies, and training.

Staff interviewed reported they use the data in various ways. The monthly review helps to correct/address issues identified; improve on staff training; adjust staff assignments, activities or schedules. The annual review allows the agency to strengthen weak areas or make corrections or adjustments. All efforts are to prevent. Even in incidents where an allegation is unfounded, the team reviews the incident to see if there is anything that could be done different or better. Staff reported the Compliance Unit reviews all data on a quarterly and annual basis for the CJPO and the Judges. Trends or concerns are identified and the policies and procedures are modified if they can make things better to reduce incidents. Staff reported the incident reviews also include sexual harassment allegations. The General Counsel maintains a spreadsheet of all the data.

**115.388(b).**

In the PAQ, the agency reported its annual report includes a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse. Agency Policy AS-906 Incident Reviews and Data Collection, Section II (C.2 (p. 3) addresses the annual report.

**115.388(c).**

In the PAQ, the agency reported its annual report is approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means. Agency Policy AS-906 Incident Reviews and Data Collection, Section II ((C.2.a) (p. 3) addresses making the annual report available to the public through the agency's website.

The CJPO interviewed reported she approves the annual reports. She reported the 2017 report was approved in June 2018. The 2017 TCJPD Annual Report, Findings and Action Plan is posted on the agency's website and is signed by the CJPO:

[https://www.traviscountytx.gov/images/juvenile\\_court/Doc/18-annual-review.pdf](https://www.traviscountytx.gov/images/juvenile_court/Doc/18-annual-review.pdf)

**115.388(d).**

In the PAQ, the agency reported it indicates the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility.

Agency Policy AS-906 Incident Reviews and Data Collection, Section II (C.2.c) (p. 4) addresses materials redacted and the nature of the materials redacted will be indicated. Staff interviewed reported the information redacted includes names, dates of birth, and any personal identifying information (PII).

**Corrective Action:**

1. The auditor recommends no corrective action.

## Standard 115.389: Data storage, publication, and destruction

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

#### 115.389 (a)

- Does the agency ensure that data collected pursuant to § 115.387 are securely retained?  
 Yes  No

#### 115.389 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means?  Yes  No

#### 115.389 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available?  Yes  No

#### 115.389 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise?  Yes  No

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

**The following evidence was analyzed in making the compliance determination:**

1. Documents:
  - a. Pre-Audit Questionnaire (PAQ)
  - b. AS-906 Incident Reviews and Data Collection (*effective 2/6/15*)
  - c. 2017 TCJPD Annual Report, Findings and Action Plan
2. Interviews:
  - a. PREA Coordinator

**Findings (By Provision):**

**115.389(a).**

In the PAQ, the agency reported it ensures that data collected pursuant to § 115.387 is securely retained.

Agency Policy AS-906 Incident Reviews and Data Collection, Section II (C.2.d) (*p. 4*) requires the secure retention of the sexual abuse data.

Staff interviewed reported the General Counsel keeps a spreadsheet of all the data.

**115.389(b).**

In the PAQ, the agency reported it makes all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means.

The 2017 TCJPD Annual Report, Findings and Action Plan is posted on the agency's website:

[https://www.traviscountytx.gov/images/juvenile\\_court/Doc/18-annual-review.pdf](https://www.traviscountytx.gov/images/juvenile_court/Doc/18-annual-review.pdf)

The auditor requested and the agency secured the incident-based aggregated data from the following facilities it contracts with, which includes public facilities:

1. 4M Granbury Youth Services
2. Hector Garza Center
3. Rockdale Regional Juvenile Justice
4. Hays County Juvenile Center
5. The Oaks Brownwood – True Core
6. Pegasus Schools, Inc.
7. Victoria Regional
8. Cornell Corrections of Texas, Inc. (Gulf Coast Trade Center)

**115.389(c).**

In the PAQ, the agency reported it removes all personal identifiers before making aggregated sexual abuse data publicly available.

Agency Policy AS-906 Incident Reviews and Data Collection, Section II (C.2.b) (p. 3) requires the removal of personal identifiers before the data is made available. The 2017 TCJPD Annual Report, Findings and Action Plan is posted on the agency's website and does not reflect personal identifiers: [https://www.traviscountytx.gov/images/juvenile\\_court/Doc/18-annual-review.pdf](https://www.traviscountytx.gov/images/juvenile_court/Doc/18-annual-review.pdf)

**115.389(d).**

In the PAQ, the agency reported it maintains sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise.

Agency Policy AS-906 Incident Reviews and Data Collection, Section II (C.2.e) (p. 4) requires data be retained for at least 10 years after the date of its initial collection, unless Federal, State or local law requires otherwise.

**Corrective Action:**

1. The agency secured the incident-based aggregated data from the facilities it contracts with, including the public facilities.
2. The agency will provide links to the private facilities' websites or make the data available by some other means.

## AUDITING AND CORRECTIVE ACTION

### Standard 115.401: Frequency and scope of audits

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

##### 115.401 (a)

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

##### 115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard.*)  Yes  No
- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the second year of the current audit cycle.)  Yes  No  NA
- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency,

were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.)  Yes  No  NA

#### 115.401 (h)

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

#### 115.401 (i)

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

#### 115.401 (m)

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

#### 115.401 (n)

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

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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

The agency underwent and completed the PREA audit process during the first three-year cycle for both the pre-adjudication (detention) and post-adjudication (residential) facilities. The agency completed the second three-year cycle for the pre-adjudication facility in 2017 and is currently completing the audit process for the post-adjudication facility during this second PREA audit cycle to ensure compliance with the first and second audit cycles.

The auditor was provided unimpeded access to all areas of the facility as requested and provided copies of all requested information: policies, supporting documentation demonstrating policy

implementation. The agency made the appropriate accommodations and arranged meeting areas for the auditor to conduct private interviews with staff and residents.

## Standard 115.403: Audit contents and findings

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

#### 115.403 (f)

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

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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

The agency's website contains all prior final audit reports for both facilities. The Detention Services Division has two prior final audit reports posted and the Residential Services Division has one prior final audit report posted on the agency's website.

## AUDITOR CERTIFICATION

I certify that:

- The contents of this report are accurate to the best of my knowledge.
- No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- I have not included in the final report any personally identifiable information (PII) about any resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

### Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.<sup>1</sup> Auditors are not permitted to submit audit reports that have been scanned.<sup>2</sup> See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Ana T. Aguirre, ATA3 Consulting, LLC

7/14/19

**Auditor Signature**

**Date**

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<sup>1</sup> See additional instructions here: <https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110>.

<sup>2</sup> See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.