

PREA AUDIT REPORT INTERIM FINAL
JUVENILE FACILITIES

Date of report: May 24, 2016

Auditor Information			
Auditor name: Lisa Hale			
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Telephone number: (512) 490-7970			
Date of facility visit: January 12-14, 2016			
Facility Information			
Facility name: McLennan Residential Treatment Center			
Facility physical address: 116 Burleson Road, Mart, Texas 76664			
Facility mailing address: <i>(if different from above)</i> Click here to enter text.			
Facility telephone number: (254)297-8200			
The facility is:	<input type="checkbox"/> Federal	<input checked="" type="checkbox"/> State	<input type="checkbox"/> County
	<input type="checkbox"/> Military	<input type="checkbox"/> Municipal	<input type="checkbox"/> Private for profit
	<input type="checkbox"/> Private not for profit		
Facility type:	<input checked="" type="checkbox"/> Correctional	<input type="checkbox"/> Detention	<input type="checkbox"/> Other
Name of facility's Chief Executive Officer: William Parks			
Number of staff assigned to the facility in the last 12 months: 55			
Designed facility capacity: 185			
Current population of facility: 65			
Facility security levels/inmate custody levels: High			
Age range of the population: 10-18			
Name of PREA Compliance Manager: Cheryl Shabaaz		Title: Program Specialist III/Compliance Officer	
Email address: cheryl.shabaaz@tjtd.texas.gov		Telephone number: (254) 297-8200	
Agency Information			
Name of agency: Texas Juvenile Justice Department			
Governing authority or parent agency: <i>(if applicable)</i> Click here to enter text.			
Physical address: 11209 Metric Blvd., Bldg. H, Suite A, Austin, TX 78758			
Mailing address: <i>(if different from above)</i> Click here to enter text.			
Telephone number: (512) 490-7130			
Agency Chief Executive Officer			
Name: David Reilly		Title: Executive Director	
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Agency-Wide PREA Coordinator			
Name: Jerome Williams		Title: PREA Compliance Director	
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AUDIT FINDINGS

NARRATIVE

The Prison Rape Elimination Act (PREA) on-site audits of McLennan Residential Treatment Center (MRTC), the Phoenix Program, and McLennan County State Juvenile Correctional Facility (McLennan CSJCF) were conducted concurrently on January 12-14, 2016. The facilities are located in Mart, Texas. This report contains findings for MRTC and the Phoenix Program which are located on one side of a fence that runs the length of the campus. The audit for these two programs was conducted by Lisa Hale, U.S. Department of Justice Certified PREA Auditor and assisted by Nicole Prather. MRTC is a Texas Juvenile Justice Department (TJJD) secure facility located within the McLennan CSJCF campus and is designed to meet the needs of youth with severe mental health needs. One dorm on the campus is designated as the Phoenix Program which serves to protect staff and youth from highly aggressive youth. Pre-audit preparation included verification of PREA audit notices being posted at least six weeks prior to the audit and containing necessary contact information and review of the Pre-Audit Questionnaire, TJJD policies, TJJD and facility procedures, and documentation supporting compliance with each standard. Questions and requests for clarification and additional information were listed by standard in a document which was sent via email to the facility's PREA compliance manager. The manager responded within the document and returned it via email to the auditor. Many follow-up phone calls were exchanged to gain further clarification and to discuss the audit process.

Upon arriving to the facility, the auditor met with the compliance manager and facility administrators to further discuss the on-site audit and facility inspection methodology. Facility supervisory staff accompanied the auditor during the walkthrough. All buildings within the security fence were reviewed including dorms, the cafeteria and warehouse, offices, interior and exterior mechanical closets, education, and the gym. During the tour, consideration was given to camera placements and potential blind spots, the level of youth supervision, indicators of any area lacking sufficient monitoring, and PREA posters. Throughout the tour, brief interviews were conducted with staff and youth in various locations.

Multiple correctional staff and specialized staff assigned to all three shifts and representing different levels of seniority and authority, youth from all dorms, volunteers, investigators, and medical staff were interviewed in private offices during the first two days of the audit. Staff and residents were selected randomly by the auditor. Following the interviews, additional documentation provided by the compliance managers was reviewed for each standard. An exit meeting with facility administrators concluded the on-site audit.

An Interim PREA Audit Report indicating overall compliance with each standard was submitted to the facility and agency PREA Coordinator. Corrective action was requested for each unmet standard. Since, the facility has provided all of the necessary documents, changes, and practices to meet compliance with all standards.

DESCRIPTION OF FACILITY CHARACTERISTICS

MRTC and the Phoenix Program are located within the McLennan County State Juvenile Correctional Facility in Mart, Texas. MRTC is a high-restriction facility serving adolescent males between the ages of 10 and 18 with severe mental health or mental illness diagnoses. Within MRTC is the Crisis Stabilization Unit, a single pod on one dorm, designed to meet the needs of youth with unstable mental health and who pose a danger to themselves or others. The unit provides crisis intervention intended to improve the youth's mental stability so that treatment in a less restrictive environment is possible. The capacity of MRTC is 64, and on the first day of the site visit, the population was 46. The Phoenix Program is a high-restriction, specialized program serving highly aggressive male youth by providing a lower staff-to-youth ratio in a structured and self-contained environment. Youth receive intensive treatment designed to reduce aggression. The capacity of Phoenix is 24, and the population on the first day of the site visit was 11. In total there are 10 buildings including five single cell housing units, education, the cafeteria, security unit, gym, and a game dorm. Youth receive medical services from the University of Texas Medical Branch (UTMB) and year-round education through TJJD. Administrative and criminal investigations are conducted in-house by the Administrative Investigations Division and the Office of the Inspector General.

SUMMARY OF AUDIT FINDINGS

The initial report findings included 30 standards in compliance, seven standards in noncompliance, one standard exceeding compliance, and three standards which did not apply. Interviews with staff and youth indicated they had received training and information regarding the right to be free from sexual abuse and harassment and were aware of multiple ways to report the allegations. The facility has an extensive video monitoring system with cameras located throughout the interior and exterior of all buildings. However, several blind spots with insufficient camera coverage were noted. These include the A dorm exterior; the kitchen walk-in refrigerator, freezer, and maintenance closet # 1417; the medical records room #1514; the exterior between the security recreation yard and the security building; pipechase on Dorm B; and the education records closet in the breakroom. During the tour it was also observed that there were camera's placed in two of the cells in the Phoenix Program, and the toilet in the gym can be viewed by the camera and others in the gym. It was reported that the two cells with cameras are not accessible to the picket staff and can only be viewed by specific upper-level management.

The facility's prevention efforts include a zero-tolerance of sexual abuse and harassment evidenced by policy, documentation, and interviews; the education of youth regarding the policy; requirements of contracted entities to adhere to the same zero tolerance; staffing plans intended to protect youth against sexual abuse; and disallowing or limiting cross-gender viewing. All of the staff interviewed said that no exigent circumstance would warrant a cross-gender pat down. The facility reported that about half of the staff had been trained according to an upcoming policy change that aligns with PREA standards which allows such searches to be conducted during an emergency. The facility conducts unannounced rounds twice per month for each of three shifts, but the majority of the rounds conducted on the late night shift occurred at the beginning or ending of the shift. Policy requires employee background checks to be conducted annually.

Evidence of responsive planning includes the training of investigators to obtain usable physical evidence. No forensic medical examinations have been necessary, but facility protocol stipulates that youth requiring the examination would be transported to a local medical center. The number of administrative and criminal investigations of sexual abuse and harassment allegations reported on the Pre-Audit Questionnaire contradicted the number of reports of investigations obtained during the on-site audit. Additionally, two facility-level hearing reports for sexual contact, a major rule violation, were uploaded during the pre-audit phase. The facility-level disposition for this case was provided, but the Office of the Inspector General investigation and disposition of this incident were not available for review. Youth and parent notifications of the outcomes of investigations were not provided during the pre- or on-site audit. Records and interviews were insufficient to determine if agency investigators attend specialized training in sexual abuse investigations.

Training and education included annual staff training addressing PREA-specific topics. One provision not specifically addressed in training is how to communicate effectively with youth who identify as lesbian, gay, bisexual, transgender, intersex, or who are gender nonconforming. Youth PREA education occurs during intake at the agency's orientation and assessment campus. Interviews with youth indicated PREA education has continued at MRTC and Phoenix through PREA-specific groups, puzzles and quizzes made by the campus PREA Compliance Manager, and signage including hotline numbers and zero tolerance. During interviews the staff stated that they had received PREA training as well as periodic games and incentives designed to refresh staff PREA knowledge. Interviews with volunteers reflected a need for additional training for volunteers who have contact with youth.

Although youth are screened for risk of sexual abuse victimization and abusiveness during intake and throughout their confinement, the screening instruments do not meet the minimum requirements. One required question not explicitly asked of youth is whether the youth identifies as lesbian, gay, bisexual, transgender, or intersex, and therefore at risk of sexual abuse. Interviews with staff and youth indicated this information is only collected if the youth self-discloses during intake. An overview of the auditor's findings was discussed in an exit meeting with the Compliance Manager, Superintendent, and other supervisory staff members. All findings were included in the Interim Audit Report which was sent to the facility on February 8, 2016.

During the corrective action phase the agency made all of the changes requested and provided proof of meeting all PREA standards.

Number of standards exceeded: 1

Number of standards met: 37

Number of standards not met: 0

Number of standards not applicable: 3

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

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

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

Policy Reviewed: 380.9337(a),(b),(d)

TJJD has a zero tolerance policy regarding all forms of sexual abuse and harassment and sanctions for those found to have participated in such prohibited behaviors. The agency has one dedicated PREA Coordinator and MRTC has one designated PREA Manager. During the interview process both individuals indicated that they have enough time to fulfill their PREA responsibilities. An agency and facility organizational chart were provided.

Standard 115.312 Contracting with other entities for the confinement of residents

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

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

Policy Reviewed: 380.9337(e)

TJJD requires that any new contract or contract renewal comply with PREA standards. The facility reported that there are six facilities in which they contract with and they provided the contracts and accompanying addendums. Documentation reflected that two of the contract facilities have completed PREA Audits.

Standard 115.313 Supervision and monitoring

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

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

corrective actions taken by the facility.

Policy Reviewed: 380.9337(e)

The facility provided a staffing plan that included all elements of the standard. At the time of the audit the facility reported that they had not deviated from their staffing plan in the past 12 months. Per the staffing plan the facility meets the ratio requirements but there is potential for lack of supervision throughout the shift due to the way the plan is written.

Documentation of unannounced rounds was provided along with snapshot pictures of the rounds being conducted. TJJJ policy requires unannounced rounds to occur at least twice per month on each shift. Based on what was provided the facility meets the standard, but most of the late night shift rounds were conducted at predictable times either at the beginning or end of the shift and none during the middle of the shift. It is recommended that the facility conduct regular rounds at random times throughout the late night shift.

Standard 115.315 Limits to cross-gender viewing and searches

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

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

Policy Reviewed: 380.9337 (c),(d),(e) and 380.9709 (c),(d),(f),(g),(i)

TJJJ policy currently states that no cross gender pat down searches will be conducted even in exigent circumstances. It is reported that the policy is in the process of changing to include that cross gender pat down searches can be conducted but only in exigent circumstances. This policy is anticipated to go into effect within a few months. The agency has started the training process on how to conduct these searches and training sign-in sheets were provided. Approximately 50% of the staff have been trained. During staff interviews, the staff stated that they are not allowed to conduct these type of searches. The staff who had been trained stated that there would never be a circumstance that would warrant a cross gender pat down searcho. It is recommended that additional training be conducted regarding these types of searches. Medical staff do not do any type of strip or cavity searches on the youth and this was verified through interviews with the medical staff.

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

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

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

Policy Reviewed: 380.9337(e)

The facility provided English and Spanish PREA written materials that are given to the youth upon their arrival. During the pre-audit phase an expired sign language contract was provided, but an updated one was provided after the audit. It was reported that there is a special education fund that the facility can use for youth who are blind or have other disabilities to meet their specific needs. It was reported that the

case managers are trained on special needs which is in the policy. During interviews with the youth it was reported that if they do not understand the PREA information the case managers will explain it to them. During staff interviews many were unaware that resident interpreters, readers, or assistants could not be utilized except in limited circumstances. It is recommended that additional training be provided to the staff regarding this standard.

Standard 115.317 Hiring and promotion decisions

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

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

Policy Reviewed: 380.9337(e), 385.8181(d), PRS 02.07 and 02.08

TJJD policy encompasses all of the requirements of this standard. A sample of files were reviewed for new hires, promotions, and volunteers and contractors for compliance. Documentation was provided showing that TJJD conducts background checks on all current employees on a yearly basis which exceeds the standard requirement of every five years. During the interview with the Human Resources Specialist she stated that if someone other than a correctional institution contacted them regarding a former employee, they would not tell them about a sexual abuse or harassment case but would advise them to do an open records check.

Standard 115.318 Upgrades to facilities and technologies

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

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

Policy Reviewed: 380.9337(a)(b)

The facility reported that they have had expansions and modifications to the two gyms on campus starting in 2012. One gym was enclosed and the other had a building extension. Construction meeting minutes as well as drawings and camera placements were provided. Documentation provided demonstrates compliance with this standard.

Standard 115.321 Evidence protocol and forensic medical examinations

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

- Does Not Meet Standard (requires corrective action)

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

Policy Reviewed: 380.9337(f), 385.8183

TJJD is responsible for conducting both criminal and administrative investigations at the MRTC facility. A uniform evidence protocol is used that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The protocol provided is the "National Protocol for Sexual Assault Medical Forensic Examinations, Second Edition, April 2013." There have not been any forensic medical examinations conducted during the review period but the examinations are done at Baylor Scott and White Hillcrest Medical Center in Waco, Texas. A Memorandum of Understanding with the Advocacy Center for Crime Victims and Children was provided for review. The crisis hotline number was posted in the case managers and mental health practitioners offices. Per the advocacy center's request the number is not given to the youth unless it is requested by the youth. This facility also has specialized mental health practitioners that can provide necessary support and counseling to victims when needed.

Standard 115.322 Policies to ensure referrals of allegations for investigations

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

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

Policy Reviewed: 380.9337(f),(i), and INS 71.01

Allegations of sexual abuse are reported to the TJJD Incident Reporting Center (IRC). The allegations are reviewed by the IRC then referred to TJJD's Office of Inspector General (OIG), the Administrative Investigation Division (AID), and Youth Services. The MRTC facility reported on the Pre-Audit Questionnaire that there were zero sexual abuse or harassment allegations referred to OIG and two cases referred to AID. The full case reports were provided for the two cases that were referred to AID. While reviewing 115.386, SARB's, it was discovered there were multiple sexual abuse and sexual harassment cases referred referred to the OIG and AID that were not included in the numbers that were reported.

Corrective Action Plan:

Develop a process in which all allegations of sexual abuse and sexual harassment reported to the IRC are tracked and accounted for so that at any given time the number of those allegations and the disposition or status of those allegations can be reported to the requestor. In addition, provide the number of alleged sexual abuse and sexual harassment reports received by the IRC, the assignment, and status of those investigations for the past 12 months.

Since the Audit:

The PREA Coordinator agreed to create and monitor the sexual abuse and sexual harassment allegations made by the facilities on a specific form CCF-351/352 beginning May 1, 2016 and a copy of the spreadsheet was provided. The plan will be to coordinate with the Incident Reporting center to review the number of allegation that have been called in by the facility and by the youth, the two numbers will be combined for a total number of allegations. It is believed this process will provide the accurate number of sexual abuse and sexual harassment allegations that each facility has during any given PREA audit cycle. Due to the discrepancies in numbers from the previous year the actual numbers of reports cannot be verified for this cycle. All reports that were classified as administrative were investigated and provided to the auditors. There were no criminal cases initially reported.

Standard 115.331 Employee training

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

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

Policy Reviewed: 380.9337(g)

TJJD policy requires the agency to provide PREA related training to all employees who may have contact with residents. Refresher training is occurring annually which is more frequent than the two year requirement for this standard. Training curriculum was provided and it covers all of the required topics in this standard. Training sign-in sheets were provided for various types of PREA training. Interviews with staff verified that PREA training is occurring in new hire orientation, annual block training, e-courses, and townhall meetings. The MRTC population consist of youth with mental health issues. The facility provided a training curriculum that was provided to the staff geared towards this population, "Working with Juveniles with Mental Illness."

Standard 115.332 Volunteer and contractor training

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

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

Policy Reviewed: 380.9337(g)

TJJD policy requires that all volunteers and contractors who have direct access to residents be trained on and understand their responsibilities regarding PREA. MRTC reported that they have 175 volunteers and contractors and they have all been trained. The training curriculum and sign-in sheets were provided for review. Two volunteers were interviewed and that stated that they were provided the training material but it was not explained to them. They stated that they do not fully understand PREA and are not aware of their duties when it comes to reporting. It is recommended that the volunteers and contractors receive more training on PREA and their reporting duties. A refresher training session for all volunteers should be done to ensure the volunteers understand the TJJD Zero Tolerance Policy, how to report an allegation, and how to maintain an appropriate relationship with youths.

Corrective Action Plan:

Provide a curriculum for training volunteers and contractors, more substantial than a handout, on zero tolerance and provide proof of volunteers receiving and understanding the training.

Since the Audit:

The PREA Compliance Manager provided a sign-in sheet and test for a "PREA Basics Training" for volunteers that occurred on 2/1/16. They reported that they utilized the training packet that they previously used for the training and added a before and after test to measure

their knowledge. The PREA Compliance Manager reported that training will occur quarterly for all volunteers. A phone interview was conducted with a volunteer to verify knowledge that was obtained from the training. The facility is now compliant with this standard.

Standard 115.333 Resident education

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

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Policy Reviewed: 380.9337(g)

The youth in TJJD are first placed in the orientation and assessment unit at the Ron Jackson State Juvenile Correctional Complex prior to being placed at any of the other TJJD facilities. During this time they receive education on PREA. Upon arrival to MRTC the youth are educated again on PREA during the intake process. Youth are provided a handbook and they are read a script that is available in English and Spanish. The resident's intake date as well as the orientation acknowledgment sheets were provided. Documentation provided reflects that this is being completed within the ten day time frame. During interviews the youth acknowledged receiving this information and stated that it occurred within the first few days of their arrival. They also acknowledged watching a PREA video which is shown to all of the residents during the intake process. Hotline numbers for reporting incidents of sexual abuse and sexual harassment are displayed throughout the facility.

Standard 115.334 Specialized training: Investigations

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

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

Policy Reviewed: 380.9337(g)

Training records that were provided were reviewed, but did not include recent training or PREA Investigator Training. The spreadsheet that was provided by the OIG reflected that one of the investigators attended several trainings last in 1992. In the interview with the OIG investigator, it was reported that although they had law enforcement experience and have had the basic PREA training, they had not yet had the PREA Training for Investigators. A review of training records also indicates the investigators have not received recent outside law enforcement training involving juveniles and sexual assaults and abuse in confined settings. AID provided an in-depth training curriculum but did not provide a current record of all officers who had completed the training.

Corrective Action Plan:

Provide current PREA Investigator Training to OIG investigators and proof of attendance. Provide proof that all AID investigators have attended PREA Investigator Training.

Since the Audit:

The OIG and AID had their investigators complete the PREA Investigators Training online through the National Institute of Corrections. Certificates were received for all of the investigators at the MRTC facility. The facility is now compliant with this standard.

Standard 115.335 Specialized training: Medical and mental health care

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

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

Policy Reviewed: 380.9337(g)

Training logs and curriculum were provided for the medical and mental health staff. Certificates for the mental health practitioners were provided showing that they completed a specialized training "Behavioral Healthcare for Sexual Assault Victims in a Confinement Setting" by the National Institute of Corrections. Sign-in sheets for PREA training done by the medical staff were provided. Medical staff at this facility do not conduct forensic medical exams.

Standard 115.341 Screening for risk of victimization and abusiveness

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

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

Policy Reviewed: 380.9337(h)

The initial intake and screening are completed at the Ron Jackson State Juvenile Correctional Complex Intake and Orientation Unit, a TJJJ facility. The MRTC facility utilizes the CCF-001 Intake Screening for Potential Sexual Aggressive Behavior and/or Sexual Victimization and CCF-036 Safe Housing Assessment and Re-assessment forms upon the youth entering the facility and periodically throughout their confinement. Access to this information is limited to case managers and administrative staff. All of the Safe Housing Re-assessments were up to date as of January 5, 2016. The two screening forms were provided. In reviewing the screening forms it was found that the screening instruments do not include all of the required elements in 115.341 (c). The screening tools provided do not directly ask or include any gender nonconforming appearance or manner or whether the youth identifies as gay, bisexual, transgender, or intersex. Interviews with the youth and specialized staff verified that these questions are not being asked.

Corrective Action Plan:

Revise the Intake, Safe Housing Assessment, and Safe Housing Re-assessment to include the following question. Do you identify as lesbian, gay, bisexual, transgender, or intersex?

Since the Audit:

The agency provided a revised CCF-001 Intake Screening for Potential Sexual Aggressive Behavior and/or Sexual Victimization. The revised screening includes the questions needed to meet this standard. The screening tool was rolled out on April 22, 2016. A review of the recent intakes for the last 30 days indicates that the new tool is being used. The facility is now compliant with this standard.

Standard 115.342 Use of screening information

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

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

Policy Reviewed: 380.9337(h),380.9745(I),INS 75.13

TJJD policy prohibits the placement of youth in isolation due to the risk of sexual victimization. Staff interviews confirmed that this is not practiced. Agency policy states that information from the risk screening to make housing, bed, work, education, and program assignments, but due to them not meeting all of the elements required in the screening tool they do not meet this standard. The screening tool does not ask whether the youth identifies as gay, bisexual, transgender, or intersex, therefore the facility was not able to identify who these particular youth are to make appropriate housing assignments. MRTC reported that they had no youth who identified as lesbian, gay, bisexual, transgender, or intersex. During interviews four of the youth identified themselves as lesbian, gay, bisexual, transgender, or intersex. TJJD policy and procedures required that the agency determine, on a case by case basis whether a placement ensures the youth's health and safety and whether the placement would present management or security problems. This would not be possible since there is not a question on the assessment that would make identity possible unless the youth identifies on their own.

Corrective Action Plan:

Revise the Intake, Safe Housing Assessment, and Safe Housing Re-assessment to include the following question. Do you identify as lesbian, gay, bisexual, transgender, or intersex? Provide documentation that this information is being used to make case by case housing, bed, program, education, and work assignments with the goal of keeping all youth safe and free from sexual abuse.

Since the Audit:

The agency provided a revised CCF-001 Intake Screening for Potential Sexual Aggressive Behavior and/or Sexual Victimization. The revised screening ask all of the required questions. The CCF-035 Safe Housing Assessment indicates if the resident has been screened for risk of victimization or abusiveness. An example of the Safe Housing Assessment was provided. The revised screening was rolled out on April 22, 2016. The facility is now compliant with this standard.

Standard 115.351 Resident reporting

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

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

Policy Reviewed: 380.9337(i)

TJJJ policy provides multiple internal ways for residents to privately report allegations. One of the numbers provided is a toll free number for the Office of the Independent Ombudsman, which is a separate state agency. Posters with hotline numbers were observed throughout the campus. Interviews with residents reflected that they are aware of the hotline numbers and that they can write grievances or verbally report sexual abuse or harassment to a staff members. Staff interviewed acknowledged the acceptance of verbal, written, anonymous, and third party reports and how to properly document them. TJJJ provides a method for staff to privately report sexual abuse or harassment by calling the Incident Reporting Center which is maintained by the OIG.

Standard 115.352 Exhaustion of administrative remedies

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

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

N/A

TJJJ is exempt from this standard because it does not have administrative procedures to address resident grievances regarding sexual abuse.

Standard 115.353 Resident access to outside confidential support services

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

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

Policy Reviewed: 380.9337(i)

A Memorandum of Understanding with the Advocacy Center for Crime Victims and Children was provided and states that the youth are given access to the hotline number after it has been determined that the youth is the victim of sexual abuse and has refused the on-site counseling services offered by TJJJ. MRTC provided a list of mental health practitioners at the facility that are qualified to provide necessary counseling. The crisis hotline number was observed posted in the case managers offices on the dorms. Per the advocacy center’s request the number is not given to the youth unless it is requested by the youth.

Standard 115.354 Third-party reporting

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the

relevant review period)

- Does Not Meet Standard (requires corrective action)

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

Policy Reviewed: 380.9337(i)

The agency has established methods to receive third party reports through the Office of Inspector General and Office of the Independent Ombudsman hotlines. This information is available on the TJJD website and a screenshot of the website was provided.

Standard 115.361 Staff and agency reporting duties

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

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

Policy Reviewed: 380.9337(j), GAP 07.03

The TJJD policy provided requires that all staff immediately report any allegation of abuse or retaliation to the Office of Inspector General. Policy prohibits staff from revealing any information related to sexual abuse to anyone other than to the extent necessary. Staff interviews demonstrated knowledge of their reporting responsibilities. Interviews with the Superintendent and PREA Compliance Manager confirmed that the alleged victims parents or guardians would be notified upon receiving the allegation of sexual abuse. A sample of parent notifications were provided.

Standard 115.362 Agency protection duties

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

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

Policy Reviewed: 380.9337(j)

The facility reported that in the past 12 months there were no incidents where the facility determined that a resident was subject to substantial risk of imminent sexual abuse. The agency policy covers this standard. Interviews with the staff confirmed that protective

actions are taken to protect the youth.

Standard 115.363 Reporting to other confinement facilities

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

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

Policy Reviewed: 380.9337(j)(k)

The TJJJD policy addresses the requirement for notifications to other facilities as well as the investigative agency upon receiving an allegation that a youth was sexually abused while confined at another facility. Staff interviews demonstrated an understanding of the reporting requirements. MRTC reported no cases that required reporting to other facilities during the audit period.

Standard 115.364 Staff first responder duties

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

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

Policy Reviewed: 380.9337(j)

The agency has established policies regarding first responder duties. Documentation of a first responder training held on October 12, 2015 was provided. Interviews with staff demonstrated knowledge of their first responder duties. The facility reported no incidents of sexual abuse in the past 12 months where the victim and abuser needed separation or where evidence could be collected.

Standard 115.365 Coordinated response

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion

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

Policy Reviewed: 380.9337(j)

The MRTC facility has developed and provided a written institutional plan to coordinate actions taken in response to allegations of sexual abuse.

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

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

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

N/A

Policy Reviewed: 380.9337(j)

TJJD does not enter into collective bargaining agreements.

Standard 115.367 Agency protection against retaliation

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

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

Policy Reviewed: 380.9337(j)

The agency has a retaliation policy that protects all residents and staff members who report sexual abuse or sexual harassment or who cooperate with an investigation. The MRTC facility has designated staff members (case managers) who are responsible for monitoring against retaliation and a list of these individuals was provided. The facility utilizes a “PREA Monitoring Form” to document that this is occurring. Two case managers were interviewed and they verified that they do monitor for retaliation and utilize the PREA Monitoring Form to do so. They both stated that they monitor the youth for a minimum of 90 days and longer if needed. Incidents where monitoring occurred were provided and the monitoring form was completed as well as chronologicals for each entry in the monitoring form.

Standard 115.368 Post-allegation protective custody

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

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

N/A

Policy Reviewed: 380.9337(j)

TJJD policy prohibits the use of segregated housing to protect residents who have alleged sexual abuse. Interviews with the staff confirmed that this is not practiced.

Standard 115.371 Criminal and administrative agency investigations

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

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

Policy Reviewed: 380.9337(k)

TJJD policy covers all of the components of this standard. All investigations of sexual abuse and sexual harassment are conducted by the Office of Inspector General or the Administrative Investigation Divisions. Sufficient training records were not provided to verify compliance with specialized training in 115.371 (b). Training curriculum was provided by the AID but there was no verification that the training occurred. The OIG provided a spreadsheet with outdated training and did not provide a sample training curriculum. Both divisions failed to provide verification that the investigators are receiving specialized training on sexual abuse investigations involving juvenile victims. Interviews with the OIG and AID demonstrated proper procedures and steps for investigating sexual abuse allegations. The AID reported and provided two cases of sexual abuse and harassment, and the OIG reported no criminal cases for the past 12 months. Paperwork provided for compliance with other standards reflected that there were more cases referred for criminal and administrative investigations that were not reported for the PREA Audit.

Corrective Action Plan:

Develop a process in which all allegations of sexual abuse and sexual harassment reported to the IRC are tracked and accounted for so that at any given time the number of those allegations and the disposition or status of those allegations can be reported to the requestor. In addition, provide the number of alleged sexual abuse and sexual harassment reports received by the IRC, the assignment, and status of those investigations for the past 12 months.

Provide current PREA Investigator Training to OIG investigators and proof of attendance. Provide proof that all AID investigators have attended PREA Investigator Training.

Since the Audit:

The PREA Coordinator agreed to create and monitor the sexual abuse and sexual harassment allegations made by the facilities on a specific form CCF-351/352 beginning May 1, 2016 and a copy of the spreadsheet was provided. The plan will be to coordinate with the Incident Reporting center to review the number of allegation that have been called in by the facility and by the youth, the two numbers will be combined for a total number of allegations. It is believed this process will provide the accurate number of sexual abuse and sexual harassment allegations that each facility has during any given PREA audit cycle. Due to the discrepancies in numbers from the previous year the actual numbers of reports cannot be verified for this cycle. All reports that were classified as administrative were investigated and provided to the auditors. There were no criminal cases reported.

Certificates of Training were provided for the 3 OIG investigators and 2 AID investigators.

Standard 115.372 Evidentiary standard for administrative investigations

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

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

Policy Reviewed: 380.9337(k)

Agency policy requires that the investigators findings must be based on a preponderance of the evidence. Interviews with investigators verified compliance with this policy and standard.

Standard 115.373 Reporting to residents

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

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

Policy Reviewed: 380.9337(k)

The facility provided several notifications, but none were for the two sexual abuse/harassment cases that the facility reported they received. The notifications provided were to the youths' parent and/or guardian as well as to the youth informing them that the case was received and that the specific staff member was reassigned. There were no notifications provided informing the youth or parents the final outcome of the case. In reviewing the notifications it was determined that there are more sexual abuse/harassment cases that were not reported to the auditor.

Corrective Action:

Develop a process in which all allegations of sexual abuse and sexual harassment reported to the IRC are tracked and accounted for so that at any given time the number of those allegations and the disposition or status of those allegations can be reported to the requestor. In addition, provide the number of alleged sexual abuse and sexual harassment reports received by the IRC, the assignment, and status of those

investigations for the past 12 months.

Develop a process that ensures the facility designee receives notification from the OIG and AID regarding the final disposition of all investigations. Provide proof that these notifications are being distributed to the youth and guardian.

Since the Audit:

This process was implemented on April 2, 2015. The notification will be provided by the OIG command staff, specifically the Lieutenants. The new process has also been formalized in OIG policy. The superintendent is responsible for the notification to the youth and family. As a reminder, superintendents will only receive this notification when a youth reports a PREA related incident. There is not a need for utilization of this notification method for other PREA related complaints since the reporter is a facility staff member.

Standard 115.376 Disciplinary sanctions for staff

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

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

Policy Reviewed: 380.9337(I)

TJJD policy covers all of the requirements in this standard. The facility reported that there have not been any incidents where staff have violated the agency sexual abuse or sexual harassment policies.

Standard 115.377 Corrective action for contractors and volunteers

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

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

Policy Reviewed: 380.9337(I)

TJJD policy covers all of the requirements in this standard. The facility reported that there have been no incidents where volunteers or contractors have violated the agency sexual abuse or sexual harassment policies.

Standard 115.378 Disciplinary sanctions for residents

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the

relevant review period)

- Does Not Meet Standard (requires corrective action)

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

Policy Reviewed: 380.9337(l), 380.9503(i)

The facility provided copies of two hearing reports conducted at the facility level indicating a disciplinary sanction of 30 days loss of privileges was given for an incident proven true. The two hearings held were for the same sexual contact incident involving two youth. The two hearings were held prior to the conclusion of the AID investigation, which could result in the youth receiving double consequence if the investigation is also proven true. The auditor was not provided with any examples of disciplinary sanctions as a result of an investigation. The interview with the Superintendent reflected that the disciplinary process takes into consideration the youths' mental disabilities or mental illness. The number of criminal and administrative investigations provided for various PREA standards were inconsistent therefore a determination of compliance with this standard cannot be made.

Corrective Action:

Provide any cases of sexual abuse investigations that resulted in disciplinary sanctions for youth on youth sexual abuse.

Since the Audit:

The facility reported that no disciplinary sanctions have been taken as a result of substantiated allegations of sexual abuse.

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

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

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

Policy Reviewed: 380.9337(m)

The initial intake and screening is completed at another TJJD facility upon the youth entering TJJD. The agency policy covers all of the requirements in this standard. The facility reported that in the past twelve months there have not been any youth who have disclosed prior victimization or anyone who has perpetrated sexual abuse. Medical and mental health staff were interviewed and verified compliance with this standard. The mental health practitioner stated that all of the youth at MRTC receive mental health counseling during the intake process at MRTC.

Standard 115.382 Access to emergency medical and mental health services

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

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

Policy Reviewed: 380.9337(m)

TJJD policy covers all of the requirements in this standard. MRTC reported no incidents of sexual abuse requiring medical attention. Interviews with medical and mental health staff demonstrated knowledge in the process for responding to sexual abuse victims. The medical staff provided documentation for the nursing protocols for alleged sexual abuse.

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

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

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

Policy Reviewed: 380.9337(m)

TJJD policy covers all of the requirements in this standard. There are no female residents at this facility. There were no cases reported that would fall under the requirements of this standard. Interviews with medical and mental health staff verified knowledge and compliance with this standard.

Standard 115.386 Sexual abuse incident reviews

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

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

Policy Reviewed: 380.9337(n)

TJJD policy covers the requirements in this standard. Of the two administrative cases reported, one of them was unfounded and did not require a SARB. In regards to the other case, the facility reported that they were just notified on January 8, 2016 that the case was closed. The facility has 30 days to conduct the SARB and the Compliance Officer stated that they will be scheduling one. Documentation of SARB's that occurred each month were provided, and for the months where there were no SARB's there was a memo stating that there were no investigations for that month. The facility provided ten cases where they conducted SARBS. All of these cases involved youth masturbation and exposures. The facility is conducting more SARB's than what is required. One of the SARB's had documentation stating that the OIG representative was not in attendance and stated that their attendance is required and it was addressed with them.

Standard 115.387 Data collection

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

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

Policy Reviewed: 380.9337(o)

TJJD collects, maintains, and reviews data on allegations of sexual abuse using a standardized instrument. This agency provided the "Department of Justice Survey of Sexual Violence" that was submitted to the Department of Justice. The PREA Coordinator demonstrated knowledge of this standard during the interview.

Standard 115.388 Data review for corrective action

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

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

Policy Reviewed: 380.9337(p)

Agency policy mandates the review of aggregate sexual abuse data to assess and improve the effectiveness of the agencies policies, practices, and training. The facility provided a memorandum of total PREA sexual abuse allegations agency wide for 2014 called "2014 PREA Review." The facility also provided a memorandum dated September 25, 2015 "Response to Annual PREA Report."

Standard 115.389 Data storage, publication, and destruction

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion

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

Policy Reviewed: 380.9337(o),(p)

TJJD policy ensures that all sexual abuse data is retained securely and is readily available to the public through their website. Data publicly available had all personal identifiers removed. The interview with the PREA Coordinator verified compliance with this standard.

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 inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

L. Hale

5/24/16

Auditor Signature

Date