PREA AUDIT REPORT ☐ **INTERIM** ☒ **FINAL**
JUVENILE FACILITIES

Date of report: January 18, 2017

Auditor Information			
Auditor name: Ana T. Aguirre, ATA3 Consulting, LLC			
Address: PO Box 19748, Austin, TX 78760			
Email: a-aguirre@prodigy.net			
Telephone number: 512-708-0647			
Date of facility visit: May 2-6, 2016			
Facility Information			
Facility name: Muerer Intermediate Sanctions Center (ISC) / Shelter			
Facility physical address: 2515 South Congress Avenue, Austin, TX 78704			
Facility mailing address: *(if different from above)*			
Facility telephone number: 512-854-7000			
The facility is:	☐ Federal	☐ State	☒ County
	☐ Military	☐ Municipal	☐ Private for profit
	☐ Private not for profit		
Facility type:	☒ Correctional	☐ Detention	☐ Other
Name of facility's Chief Executive Officer: Cory Burgess			
Number of staff assigned to the facility in the last 12 months: 113			
Designed facility capacity: 118 in ISC / 10 in Shelter			
Current population of facility: 46			
Facility security levels/inmate custody levels: Maximum in ISC / Minimum in Shelter			
Age range of the population: 13-18			
Name of PREA Compliance Manager: Leslie Dudek		**Title:** Accreditation and Compliance Officer	
Email address: leslie.dudek@traviscountytx.gov		**Telephone number:** 512-854-5615	
Agency Information			
Name of agency: Travis County Juvenile Probation Department			
Governing authority or parent agency: *(if applicable)* Travis County Juvenile Board			
Physical address: 2515 South Congress Avenue, Austin, TX 78704			
Mailing address: *(if different from above)*			
Telephone number: 512-854-7000			
Agency Chief Executive Officer			
Name: Estela P. Medina		**Title:** Chief Juvenile Probation Officer	
Email address: estela.medina@traviscountytx.gov		**Telephone number:** 512-854-7069	
Agency-Wide PREA Coordinator			
Name: Brandy Baptiste		**Title:** Case Work Manager - Compliance Unit	
Email address: brandy.baptiste@traviscountytx.gov		**Telephone number:** 512-854-5675	

AUDIT FINDINGS

NARRATIVE

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 May 2-6, 2016, 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 offices. A subsequent onsite audit was conducted on November 29, 2016, to assess and verify the implementation of certain PREA policies and procedures. The second onsite review reflected the proper measures had been taken and implemented. During the initial weeklong onsite audit, the last two and a half days focused primarily on the post-adjudication facility. The pre-adjudication facility was the primary focus of the audit during the first half of the week; the post-adjudication facility was the primary focus of the audit during the last half of the weeklong onsite audit visit. 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 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).

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). 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.

In preparation for the onsite audit, the facility posted the required PREA Audit Notices on March 12, 2016, 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. During the onsite audit, the auditor noted the notices were posted in the following areas: ISC Entrance, ISC Lobby, Cafeteria, Infirmary, Gym, Classrooms, Library, Medical, Public Visitation Area, Staff Break Room, Visitation, each Housing Unit, and the Shelter Living Room. The notices were printed in bright neon colors (pink and green) 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-audit phases.

An entrance interview with key staff, including Estela P. Medina, Chief Juvenile Probation Officer; Cory Burgess, Division Director of Residential Services; Brandy Baptiste, PREA Coordinator; and Leslie Dudek, PREA Complinace Manager; was held on Monday, May 2, 2016. The audit process was explained with the staff. An exit interview was conducted on Friday, May 6, 2016.

During the onsite audit phase, the auditor was provided a meeting space to conduct confidential interviews with staff. The auditor was provided with private rooms to conduct confidential interviews with residents. Formal interviews were conducted with facility staff, residents, contractors, volunteers, and interns. The auditor formally interviewed 13 residents from all of the occupied housing units; over 40 staff, of which 37 were specialized staff and included contractors and volunteers. The auditor interviewed the Chief Juvenile Probation Officer, Division Director of Residential Services, the PREA Coordinator, and the PREA Compliance Manager. Specialized staff interviewed included the agency contract administrator, intermediate/higher level facility staff, medical and mental health staff, administrative (human resources) staff, volunteers and contractors, investigative staff, staff that perform screening for risk of vitimization and abusiveness, staff who supervise residents in isolation, incident review team staff, designated staff member charged with monitoring retaliation, security staff who have acted as first responders, intake staff and random sample of staff. Staff from all three shifts (6:00 AM - 2:00 PM, 2:00 PM - 10:00 PM; and 10:00 PM - 6:00 AM) were interviewed. The auditor interviewed randomly selected residents, and a minimum of one from each occupied housing unit. 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 allegations 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.

The auditor toured the facility and observed the following: the facility's configuration; location of cameras; staff to resident ratios; housing unit layout including the shower areas; placement of PREA related information; resident intake, admission, and search procedures; resident programming; and areas designated for staff support/operational areas. The auditor noted that shower areas allow residents to shower one at a time. At a minimum, each housing unit is equipped with at least one central shower/restroom. Residents are only allowed to shower one at a time. The auditor also conducted informal interviews of staff and residents while conducting the tour and arranged her schedule to allow for onsite observation of each shift.

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.

DESCRIPTION OF FACILITY CHARACTERISTICS

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. The facility reported it contains two buildings. The facility's designed capacity is 118 beds for the ISC and 10 beds for the Halfway House (Shelter). The ISC has 10 housing units, and the Shelter has one. Each housing unit is equiped with a day room and at least one central restroom/shower. The facility has 10 specialized housing rooms used for segregation in the ISC. The facility operates treatment focused programs. Two of the treatment programs include a violent offender treatment program and a sex offender treatment program. One of the housing units is currently designated to house female residents; nine are currently designated for male residents. One unit was vacant at the time of the initial onsite audit.

The facility operates a health clinic with 24-hour nurses to provide medical care for minor health conditions, access to on-call physicians, and physician and dentist on-site at least once a week.

During the onsite audit, the current populaton stood at 46 residents, which included 42 male residents and 4 female residents. The agency reported 118 residents had been admitted to the facility in the past 12 months, with 108 residents whose length of stay in the facility was for 10 or more day, and 116 residents admitted to the facility whose length of stay in the facility was for 72 or more hours. The agency reported 113 employed staff at the facility during the past 12 months and 21 of those individuals are no longer employed. The agency reported 47 contracts with contractors who might have contact with residents and 61 volunteers and contractors currently authorized to enter the facility.

SUMMARY OF AUDIT FINDINGS

During the past 12 months, the Muerer Intermediate Sanctions Center (ISC) / Shelter Post-Adjudication Facility reported one allegation of sexual abuse, which resulted in a administrative and criminal investigation. The allegation was referred to law enforcement. The victim in the case wanted to pursue charges, which resulted in a Class C citation that was subsequently transferred to juvenile court. An incident review was conducted related to this case. Although required to conduct an incident review of all sexual abuse allegations, the auditor noted the agency is working towards conducting incident reviews on all sexual harassment allegations as well as all serious incidents. Additionally, the agency has requested additional cameras and an enhanced video surveillance monitoring system in an effort to enhance the sexual safety of all residents.

The agency is policy driven and, although not required, has developed and implemented a policy for nearly every provision of each standard. The auditor made an effort to accurately reflect the applicable agency policy(ies) for each provision of each standard. In reviewing each provision and the applicable policy, the auditor reviewed applicable documentation and/or interviewed staff to confirm the policy had been implemented. Based on staff and resident interviews, there was a strong indication the PREA standards are implemented as required and in accordance with the agencies policies.

Overall, the interviews of residents reflected they were aware of PREA, and acknowledged familiarity with how they could report allegations of sexual abuse and sexual harassment. All residents interviewed reported feeling safe at the facility. The auditor noted that residents receive the PREA education and comprehensive information verbally and in written format (Orientation Packet, Resident Handbook, PREA Brochures) during intake and orientation, as well as monthly. All staff, including specialized and contract staff, volunteers, and interns, interviewed indicated they were knowledgeable of PREA and of their roles and responsibilities related to reporting requirements as well as awareness of the procedures to follow if they are the first responders to any PREA related allegation. Documentation reviewed reflected the efforts the agency has made to develop and implement policies and procedures to meet the PREA standards.

Number of standards exceeded: 10

Number of standards met: 29

Number of standards not met: 0

Number of standards not applicable: 2

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.

115.311(a)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS- 901, AS-902, AS-903, AS-906, and AS-209. Resident Handbook, PREA Posters, and PREA Brochures.

FINDINGS:
During the onsite audit phase, the auditor recommended Agency Policy AS-901, be modified to incorporate the complete definition for "sexual abuse" as referenced in the definition of the PREA Standards. It was also recommended agency policy address sanctions for residents involved in such conduct. Agency Policy AS-901, and the resident handbook, were modified to include sexual abuse by a resident and sanctions for residents involved in such conduct. This policy and resident handbook revisions reflected what is already agency practice and demonstrated full compliance with this provision. Agency Policies AS-901, AS-902, AS-903, AS-906, and AS-209 address the requirements of this provision. The agency mandates a zero tolerance policy towards all forms of sexual abuse and sexual harassment and outlines the agency's strategies on preventing, detecting and responding to such conduct. Agency polices addressed "Preventing" sexual abuse and sexual harassment through the designation of a PREA Coordinator and PREA Compliance Manager, Criminal History Background Checks and Child Abuse Registry Checks (Staff, Contractors, and Volunteers, as applicable), Training (Staff, Volunteers, and Contractors), Staffing, Intake Screening, Classification, Resident Education, Posting of Signage (PREA Posters, etc…), and Contract Monitoring. The policies addressed "Detecting" sexual abuse and sexual harassment through Training (Staff, Volunteers, and Contractors), and Intake Screening. The polices addressed "Responding" to allegations of sexual abuse and sexual harassment through Reporting, Investigations, Victim Services, Medical and Mental Health Services, Disciplinary Sanctions for Staff (including notification of licensing agencies), Incident Review Teams, and Data Collections and Analysis. The auditor noted the Resident Handbook, PREA Posters, and PREA Brochure do address sexual abuse by another resident, and the Resident Handbook does address sanctions for residents when involved in such conduct. Based on staff interviews and a review of practices, it was noted staff closely monitor for resident-on-resident sexual misconduct in accordance with PREA, allegations are reported and investigated, and residents are held accountable.

115.311(b)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-902, Section III (A), Pg. 2. Agency's organizational chart.

INTERVIEWS:
PREA Coordinator.

ONSITE REVIEW (TOUR OBSERVATIONS):
No on-site observations were required for this provision, although the auditor noted Ms. Baptiste has an office designated for her and the two PREA Compliance Managers she supervises.

FINDINGS
Although not required, Agency Policy AS-902, Section III (A), Pg. 2, addresses the position of the PREA Coordinator, which outlines the roles and responsibilities of the position and calls for the position being allowed sufficient time and authority to develop, implement, and oversee Department efforts to comply with the PREA standards in each facility. The agency's organizational chart reflects that the PREA Coordinator position is an upper-level position and is agency-wide. The PREA Coordinator position reports to the Agency's General Counsel who reports directly to the Chief Juvenile Probation Officer. The PREA Coordinator was interviewed. She reported having enough time to focus on the PREA standards from and the freedom to divert responsibilities to other staff as needed to focus on the audit beginning in 2012 and 2013. She oversees two Compliance Managers and reports to the agency's General Counsel. The PREA Coordinator added that the PREA compliance process began as a result of the ACA PREA standards, and that in 2009, she and the agency noted the first draft of the PREA Standards and began the process at that time. She reported the agency has provided for the PREA Coordinator and PREA Compliance Managers to attend the Correctional Accreditation Manager's Association (CAMA) Conferences in response to PREA and plans are underway to attend and participate in the 2016 CAMA conference. The PREA Coordinator reported she oversees standards compliance for PREA, the American Correctional Association (ACA), Texas Juvenile Justice Department (TJJD), and the Department of State Health Services (DSHS). A review of the agency policy, agency's organization chart, and based on the interview, the designated agency's PREA Coordinator, the auditor determined the agency demonstrates it substantially exceeds the requirements of this provision of this standard.

115.311(c)
POLICY AND DOCUMENT REVIEW:

Agency Policy AS-902, Section III (A), Pg. 2. Agency's organizational chart.

INTERVIEWS:
PREA Compliance Manager.

ONSITE REVIEW (TOUR OBSERVATIONS):
No on-site observations were required for this provision, although the auditor noted the PREA Compliance Manager has an office she shares with the second PREA Compliance Manager and is located immediately outside the PREA Coordinator's Office.

FINDINGS
Although not required, Agency Policy AS-902, Section III (A), Pg. 2, addresses the position of the PREA Compliance Manager, which outlines the roles and responsibilities of the position and calls for the postion being allowed sufficient time and authority to develop, implement, and oversee Department efforts to comply with the PREA standards in each facility. The agency's organizational chart reflects that the PREA Compliance Manager position reports to the PREA Coordinator who reports directly to the Agency's General Counsel. The PREA Compliance Manager was interviewed. She reported having enough time to focus on PREA related activities. The PREA Compliance Manager reported the Compliance Unit has many responsibilities and PREA is one of them She reported her supervisor, the PREA Coordinator, has done a lot. A review of the agency policy, agency's organization chart, and based on the interview, the designated facility's PREA Compliance Manager, the auditor determined the agency demonstrates it substantially exceeds the requirements of this provision of this standard.

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.

115.312(a)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-902, Section III (H) (1), Pg. 6. Contracts.

FINDINGS
Although not required, Agency Policy AS-902, Section III (H) (1), Pg. 6, addresses this provision. The agency reported there were nine (9) contracts for the confinement of residents that the agency had entered into or renewed with private entities or other government agencies. A review of all the contracts reflected the entity's obligation to adopt and comply with the PREA standards. A review of the agency policy and the nine (9) contracts reflected all the contracts met the required entity's obligation to adopt and comply with the PREA standards.

115.312(b)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-902, Section III (H) (1), Pg. 6. Contracts.

INTERVIEWS:
Contract Administrator

FINDINGS
Although not required, Agency Policy AS-902, Section III (H) (1), Pg. 6, addresses this provision. The agency reported all nine contracts require the agency to monitor the contractor's compliance with the PREA standards. The agency's Contract Administrator was interviewed and reported she is required to maintain regular contact with every resident placed in a contacting facility. Monthly face-to-face contact with the residents and collaboration with the parents of the residents is required. If a resident or parent voices any concern or outcry, she will follow-up and work with the compliance team. If there are concerns, agency protocol requires the resident be removed from the facility and the facility allowed time to make corrective action and address the concerns. Corrective actions are addressed before the facility is reconsidered. Parents are always apprised of the status. Outcries can be made from the facility, the probation officer or the parents, which would result in she immediately contacting the child and facility regarding the child's safety. Notification would also be made to law enforcement and the TJJD. The Contract Administrator reported she annually collects credentialing documentation for each facility: facility license; staff licenses or certifications; daily schedule; review of CPS, DFPS, and TJJD monitoring reports or the licensing agency's website regarding the facility's status; and tours the facility. New facilities being considered for contracting purposes follow a vetting process, including reference checks with other counties, with all information being presented to the agency's leadership for review and approval. All placements involve the input of the resident being considered for placement in the facility. The Contract Administrator reported PREA compliance results

are completed and that the PREA Coordinator has implemented a tracking process for this. The PREA Coordinator reported being made aware of allegations of sexual abuse or sexual harassment. A review of the agency policy, agency contracts and interview with the contract administrator and PREA Coordinator demonstrated the agency substantially exceeds the requirements of this provision and this standard.

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.

115.313(a)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-902, Section III (A) (2), Pg. 2, and (D) (3), Pg. 3. Staffing Plan. Gardner-Betts Juvenile Probation Center Security Upgrade-Business and Technical Requirements Report.

INTERVIEWS:
Division Director of Residential Services, and PREA Compliance Manager.

FINDINGS
Although not required, Agency Policy AS-902, Section III (A) (2), Pg. 2, and (D) (3), Pg. 3, addresses this provision. The agency submitted an Annual Staffing Plan Review Memo dated November 13, 2015 and reflecting the annual staffing plan review was conducted on October 6, 2014, for both facilities: Pre-Adjudication and Post-Adjudication Facility. The agency reported the facility's average daily number of residents is 58 and that the daily number of residents in which the staffing plan was predicated on is 120. It was noted that the Pre-Adjudication Facility's designed facility capacity is 120, and the Post-Adjudication Facility's designed facility capacity is 128 (110 for Intermediate Sanctions Center and 10 for Halfway House). When requested, the facility provided the "Gardner-Betts Juvenile Probation Center Security Upgrade-Business and Technical Requirements" Report dated 7-5-13. The report was generated by the agency in response to its commitment in instituting the intent and requirements of the Federal Prison Rape Elimination Act and requesting video surveillance upgrades. The auditor interviewed the Division Director of Residential Services and the PREA Compliance Manager. Staff reported the management team meets on an annual basis to develop the staffing plan. The team reviews staffing levels, incidents, the need for additional staff, staff training, and the mandate to maintain the required resident to staff ratios. Staff reported a staffing plan is in place and that the PREA Coordinator maintains it and distributes copies to the management team. Staff reported a need for additional camera/video surveillance technology and written proposals for this technology have been previously submitted. Staff reported pending the video surveillance upgrades, blind spots have been identified and addressed. Staff reported they take into consideration the composition of the resident population, and their program needs (the facility operates a violent offender and sex offender program), the size of the group and any movement is coordinated between staff supervising the groups, and staff scheduling. Additionally, staff consider the residents' treatment and treatment goals on a case-by-case basis and work extensivley with the Mental Health Treatment Team. Staff reported the afternoon shift is the busiest - vocational programming occurs during the day and treatment programming occurs during the evening. Staff also reported they comply with the TJJD staff to resident ratios and standards, PREA standards, DSHS rules, and any other safety code requirement. When reviewing incidents, staff consider all incidents, including allegations that are unsubstantiated. Specific to PREA related incidents, staff consider how the incident occurred and what is needed to change, such as policy or practice. Additionally, staff reported other relevant factors considered include the consideration of any concerns or suggestions staff present at anytime during the year. Staff reported, to ensure compliance with the staffing plan, they conduct walk arounds with the supervisory staff, supervisors regularly review staff assignments to ensure there is appropriate supervision of residents. If there is a 'hold mandate,' the facility initiates mandatory overtime. During the onsite audit, a review of the agency policy, staff interviews, and the agency's staffing plan indicated all the elements are addressed. The agency has implemented a process seeking additional video monitoring technology to enhance the supervision and safety of the residents. The initial staffing plan presented combined both the pre and post-adjudication facilities. A staffing plan specific to the post-adjudication facility that addresses each element is required. It was recommended a staffing plan specific to the post-adjudication facility that addresses each element listed in this provision be developed and the requests for video monitoring technology continue in light of the limited number of cameras currently in place for the size and security level of the facility as well as the resident's custody level. In response to the corrective action, the agency developed a staffing plan specific to the post-adjudication facility on May 6, 2016. The staffing plan does address each element of this provision. The department noted in the plan that it will continue to prioritize the video surveillance system project to enhance and supplement supervision in resident program areas to protect the residents from sexual abuse and sexual harassment. Supplemental supporting documentation specific to the video surveillance system demonstrated the department's ongoing efforts towards full implementation of this project.

115.313(b)
POLICY AND DOCUMENT REVIEW:
The agency reported no deviations with the staffing plan in place, therefore there was no documentation provided to review.

INTERVIEWS:
Division Director of Residential Services.

FINDINGS
The auditor interviewed the Division Director of Residential Services. He reported he has not encountered a situation in which they are unable to meet the requiremnts of the staffing plan. He reported staff make every effort to plan ahead. Based on the staff interview, there was no indication there had been any deviation from the staffing plan.

115.313(c)
POLICY AND DOCUMENT REVIEW:
Facility staffing ratios.

INTERVIEWS:
Division Director of Residential Services.

FINDINGS
The PREA staffing ratios for this provision go into effect on October 1, 2017. Currently, the facility complies with the mandated supervision ratios in the TJJD standards, which require that secure facilities maintain a 1:8 facility-wide ratio during program hours and a 1:18/20 ratio during non-program hours. The auditor interviewed the Division Director of Residential Services. He reported the facility complies with the TJJD standards. This provision is not applicable for this facility until October 1, 2017.

115.313(d)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-902, Section III (A) (5), Pg. 2, and (D) (10), Pg. 4. Staffing Plan. Gardner-Betts Juvenile Probation Center Security Upgrade-Business and Technical Requirements Report

INTERVIEWS:
PREA Coordinator.

FINDINGS
Although not required, Agency Policy AS-902, Section III (A) (5), Pg. 2, and (D) (10), Pg. 4, addresses this provision. The agency reported no deviations with the staffing plan in place, therefore there was no documentation to review. It was noted, the staffing plan provided is for both the pre-adjudication and post-adjudication facility. When requested, the facility provided the "Gardner-Betts Juvenile Probation Center Security Upgrade-Business and Technical Requirements" Report dated 7-5-13. The report was generated by the agency in response to its commitment in instituting the intent and requirements of the Federal Prison Rape Elimination Act and requesting video surveillance upgrades. The auditor interviewed the PREA Coordinator. She reported she is consulted regarding any assessments of, or adjustments to, the staffing plan, which occur annually. She reported she is asked what type of standards does the agency need to worry about. The agency is preparing for the October 2017 PREA staffing ratios. When needed, the agency goes into mandatory overtime. During the onsite audit, a review of the agency policy, staff interview, and the agency's current staffing plan indicate all the elements are in place. The agency has implemented a process seeking additional video monitoring technology to enhance the supervision and safety of the residents. The initial staffing plan presented combined both the pre and post-adjudication facilities. A staffing plan specific to the post-adjudication facility that addresses each element is required. It was recommended a staffing plan specific to the post-adjudication facility be developed and the requests for video monitoring technology continue in light of the limited number of cameras currently in place for the size and security level of the facility as well as the resident's custody level. In response to the corrective action, the agency developed a staffing plan specific to the post-adjudication facility on May 6, 2016. The staffing plan does address each element of this provision. The department noted in the plan that it will continue to prioritize the video surveillance system project to enhance and supplement supervision in resident program areas to protect the residents from sexual abuse and sexual harassment. Supplemental supporting documentation specific to the video surveillance system demonstrated the department's ongoing efforts towards full implementation of this project.

115.313(e)
POLICY AND DOCUMENT REVIEW:
Policy AS-902, Section III (E) (4), Pgs. 4-5. Management Walk-Thru Forms.

INTERVIEWS:
Intermediate and Higher-Level Facility Staff

ONSITE REVIEW (TOUR OBSERVATIONS):
A review of a log entries indicated the upper management unannounced rounds, which are separately documented, are documented and provide additional supporting documentation.

FINDINGS
Agency Policy AS-902, Section III (E) (4), Pgs. 4-5, addresses this provision. Management Walk-Thru Forms are used to document unannounced rounds, which are the responsibility of the Division Managers and Accreditation and Compliance Unit. Intermediate and Higher-Level Facility Staff were interviewed by the auditor. Staff reported there are three levels of management within the facility staff that conduct unannounced rounds: Shift Supervisor, Division Manager, and Division Director. Outside of the facility, the PREA Coordinator and PREA Compliance Managers, Assistant Chief Juvenile Probation Officer and Chief Juvenile Probation Officer also conduct unannounced rounds. One staff member, who had recently promoted one month ago, reported he does not yet conduct the unannounced rounds by himself as he is still in training. He reported he nevers conducts the

unannounced rounds at the same time and documents the following: staff are at their assigned posts, clients are safe, log entries are current, and the area is safe. He reported he then signs the log book to document he was onsite. Rounds are documented on the Management Walk-Thru Form and in the PREA Walk-Thru Logs. Staff reported different strategies utilized to prevent staff from alerting other staff that an unannounced round was being conducted. Staff also reported at the conclusion of the walk-thrus, they can view each other's walk-thru notes. The notes are also reviewed by the following staff: General Counsel, Assistant CJPO, CJPO, Compliance Team, Division Manager and Division Director. A review of the agency policy, completed Management Walk-Thru Forms, and staff interviews, indicate multiple levels of management conducting unannounced rounds on all shifts. The upper management walk-thrus are also documented in the log entries within the housing units, which the auditor determined the agency demonstrates it substantially exceeds the requirements of this provision.

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.

115.315(a)
POLICY AND DOCUMENT REVIEW:
Agency Policy RS-6.120, Section III (D) (3) (c), Pg. 4. Agency Memo.

INTERVIEWS:
PREA Coordinator.

FINDINGS
Agency Policy RS-6.120, Section III (D) (3) (c), Pg. 4, addresses this provision. Agency policy requires strip searches are conducted by staff of the same gender as the juvenile. The agency reported there have been no incidents of cross-gender strip or cross-gender visual body cavity searches of residents. The agency reported TJJD standards also prohibit cross-gender strip searches and cross-gender visual body cavity searches. Because the state standards do not have provisions for exigent circumstances, the facilities do not conduct cross-gender strip searches or cross-gender visual body cavity searches. State standards do not have provisions for exigent circumstances, therefore facilities are not allowed to conduct cross-gender strip searches or cross-gender visual body cavity searches. This was reported via memo by the agency to the auditor, and an informal interview with the PREA Coordinator confirmed this practice. A review of the agency policy, agency memo, and staff interviews indicate no cross-gender strip searches or cross-gender visual body cavity searches are conducted.

115.315(b)
POLICY AND DOCUMENT REVIEW:
Agency Policy RS-6.120, Section III (D) (1) (c), Pg. 3.

INTERVIEWS:
Random Selection of Staff, and Random Selection of Residents.

FINDINGS
Agency Policy RS-6.120, Section III (D) (1) (c), Pg. 3, addresses this provision. Agency policy requires strip searches are conducted by staff of the same gender as the juvenile. The agency reported there have been no incidents of cross-gender strip or cross-gender visual body cavity searches of residents. The agency reported TJJD standards also prohibit cross-gender strip searches and cross-gender visual body cavity searches. The auditor interviewed a random selection of staff and random selection of residents. Staff reported they are prohibited from conducting cross-gender searches, but are trained to conduct cross-gender pat-down searches in the event of an emergency or exigent circumstance. Staff reported there is always adequate levels of staffing to ensure cross-gender searches do not occur. All staff reported they had not conducted a cross-gender search or heard of one taking place since their employment with the agency. All residents interviewed reported they have been searched only by same-gender staff at all times. Staff interviews reflected staff are not allowed to conduct cross-gender pat-down searches and resident interviews reflected only same gender staff have conducted pat-down searches on them. A review of the agency policy and staff interviews indicates no cross-gender pat-down searches are conducted. Resident interviews confirmed no cross-gender searches are conducted. The auditor noted, although agency policy prohibits cross-gender searches, staff are trained to conduct cross-gender pat-down searches in the event of an emergency or exigent circumstance.

115.315(c)
POLICY AND DOCUMENT REVIEW:
Agency Policy RS-6.120, Section III (D) (2) (b), Pg. 2, and (D)(4)(c), Pg. 5.

FINDINGS
Agency Policy RS-6.120, Section III (D) (2) (b), Pg. 2, and (D) (4) (c), Pg. 5, addresses this provision. Agency policy requires strip searches are conducted by staff of the same gender as the juvenile. Agency policy requires female JSOs frisk search female juveniles and male JSOs frisk search male juveniles. The agency reported there have been no incidents of cross-gender strip cross-gender visual body cavity searches of residents, therefore there was no documentation to review. The agency reported TJJD standards also prohibit cross-gender strip searches, cross-gender visual body cavity searches and cross-gender pat-down searches. Because the state standards do not have provisions for exigent circumstances, the facilities do not conduct cross-gender strip searches, cross-gender visual body cavity searches, or cross-gender pat-down searches.

115.315(d)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-902, Section III (E) (5), Pg. 5, and RS-7.20, Section III (A) (4), Pg. 2.

INTERVIEWS:
Random Selection of Staff, and Random Selection of Residents.

ONSITE REVIEW (TOUR OBSERVATIONS):
During the tour of the facility, the auditor noted every time staff of the opposite gender entered a housing unit, the staff would announce themselves accordingly. The auditor noted the facility also has magnetized laminated signs at the entrance of each housing unit indicating when the residents of that housing unit are showering. Staff explained the signs are posted just outside the door when the residents are showering an alert staff of the opposite gender not to enter until the sign is removed, which indicates the residents in the housing unit are not finished showering.

FINDINGS
Agency Policies AS-902, Section III (E) (5), Pg. 5, and RS-7.20, Section III (A) (4), Pg. 2, address this provision. During the onsite audit, a review of the policies indicates the only element not addressed in this provision is enabling residents to perform bodily functions without nonmedical staff of the opposite gender viewing them. It was recommended agency policy be enhanced to prohibit opposite gender viewing by staff of residents while residents are performing bodily functions, except in exigent circumstances or when such viewing is incidental to routine cell checks. In response to the recommendation, Agency Policy RS-7.20, Section III (A) (4), Pg. 2, was modified to address this provision. Although, currently, there are no cameras in any of the housing units or cells, therefore no opportunity for staff of the opposite gender to view residents while performing bodily functions, if the agency secures additional video monitoring technology, careful consideration must be taken regarding the placement of all cameras to ensure compliance with this provision and other related PREA standards. Staff interviews reflected staff are aware and are required to announce themselves when entering a housing unit with residents of the opposite gender and resident interviews reflected staff of the opposite gender consistently announce themselves upon entering their housing units. Residents interviewed reported staff of the opposite gender do announce themselves and that they would never be in a state of undress in front of opposite gender staff. A review of the agency policy, staff and resident interviews, observations of staff announcing themselves when entering a housing unit with residents of the opposite gender, as well as the practice of posting a magnetized sign indicating when residents are showering to avoid staff of the opposite gender from entering the housing unit, the auditor determined the agency demonstrated every precaution is made to ensure residents are afforded privacy when showering, and changing clothes.

115.315(e)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-1203, Section III (A) (4), Pg. 3, and (I)(3), Pg. 6, and RS-6.120, Section III (D) (5), Pg. 6.

INTERVIEWS:
Random Sample of Staff. At the time of the onsite audit, there were no Transgender or Intersex Residents at the facility, therefore no residents were interviewed specific to this provision.

FINDINGS
Agency Policies AS-1203, Section III (A) (4), Pg. 3, and (I) (3), Pg. 6, and RS-6.120, Section III (D) (5), Pg. 6, address this provision. Staff interviews reflected staff are prohibited from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. Staff also reported the determination of the resident's genital status would be made by medical staff. There were no identified transgender or intersex residents available to interview during the onsite audit.

115.315(f)
POLICY AND DOCUMENT REVIEW:
Agency Policy RS-6.120, Section III (B), Pg. 2. The agency reported, "Despite the state provisions not allowing for cross-gender viewing and searches, the Department has trained a percentage of the direct supervision staff in Residential Services using the cross-gender pat search training video available on the PREA Resource Center website that was produced by the Moss Group. Training documentation reflected staff attended and participated in "Cross-Gender and Transgender Pat Searches" training via a webinar and noting the instructors as, "National PREA Resource Center and the Moss Group, Inc.

INTERVIEWS:
Random Sample of Staff.

FINDINGS
Although not required, Agency Policy RS-6.120, Section III (B), Pg. 2, addresses this provision. A review of the agency policy, training documentation, and staff interviews indicate are prohibited from conducting cross-gender pat-down searches, but a select staff are trained on how to conduct cross-gender pat-down searches and searches of transgender and intersex residents.

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.

115.316(a)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-902, Section III (D) (8), Pg. 3, (F-G), Pgs. 5-6, and RS-1.35, Section III (J), Pg. 7. Interpreter Services for Deaf & Hard of Hearing Brochure, PREA Brochure, PREA Posters, and Resident Handbook.

INTERVIEWS:
Chief Juvenile Probation Officer. At the time of the audit, there were no limited English proficiency residents at the facility, therefore no resident was interviewed specific to this provision.

FINDINGS
Agency Policy AS-902, Section III (D) (8), Pg. 3, (F-G), Pgs. 5-6, and RS-1.35, Section III (J), Pg. 7, address this provision. An informational brochure for Interpreter Services for Deaf & Hard of Hearing provides staff with information on how to secure interpretation services for deaf and hard of hearing residents. The PREA Brochure, PREA Posters, and Resident Handbook are also available in Spanish. The Chief Juvenile Probation Officer reported the PREA posters, PREA brochures and resident handbooks are available in English and Spanish, the Hotline Numbers can take calls from Spanish speaking callers, intake staff provide information to the residents in English and Spanish, medical and mental health staff conduct early assessments to detect mental health or cognitive disabilities, including physical disabilities. Once disabilities are identified, proper staff assignments are done in response to the residents' disabilities, including medical and counseling services. Bilingual staff have been identified in response to the language needs of the residents and their families. The local mental health department provides training for staff in response to kids in trauma or crisis and vulnerable. Additional staff interviews (formal and informal) indicated several strategies are in place to address multiple types of disabilities residents may have and respond accordingly.

115.316(b)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-902, Section III (G) (2), Pgs. 5-6. Interpreter Services for Deaf & Hard of Hearing. The PREA Brochure, PREA Posters, and Resident Handbook are also available in Spanish. Multiple staff have been identified as bilingual and are available as needed.

INTERVIEWS:
At the time of the audit, there were no limited English proficiency residents at the facility, therefore no resident was interviewed specific to this provision.

FINDINGS
Agency Policy AS-902, Section III (G) (2), Pgs. 5-6, addresses this provision. Materials are available in Spanish and additional interpreter services can be secured as needed. Multiple staff have been identified as bilingual and are available as needed.

115.316(c)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-217B, Section III (D) (4) (c), Pg. 3-4; AS-903, Section III (C) (1) (b), and (D) (2) (b), Pg. 5, and RS-2.50, Section III (C) (1) (b), Pg. 5 and (D) (2) (b), Pg. 5.

INTERVIEWS:
Random Sample of Staff.

FINDINGS
Agency Policies AS-217B, Section III (D) (4) (c), Pg. 3-4; AS-903, Section III (C) (1) (b), and (D) (2) (b), Pg. 5, and RS-2.50, Section III (C) (1) (b), Pg. 5 and (D) (2) (b), Pg. 5, address this provision. Multiple staff have been identified and can translate in Spanish. Staff interviewed reported they would never use residents to interpret for another resident and that there was always sufficient staff to interpret.

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.

115.317(a)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-203, Section III (F) (3) (f-i), Pgs. 3-4, and AS-209, Section I (B) (7), Pg. 2. Agency Forms.

FINDINGS
Agency Policies AS-203, Section III (F) (3) (f-i), Pgs. 3-4, and AS-209, Section I (B) (7), Pg. 2, and agency forms address this provision. Agency policy defines staff to include interns, volunteer or contracted program services staff. The agency contracts with the Austin Independent School District (AISD) for education services and are also subjected to a criminal background check, including a fingerprint based background check. AISD provided the agency with a list of teachers that had been vetted through its system and approved for assignment to the Juvenile Facilities. A review of 8 randomly selected staff, volunteer and contract staff HR files indicated timely criminal background checks, all within the past two years. All files reflected the three required questions in this provision are included and staff affirmed by signing the form

115.317(b)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-203, Section III (F) (6), Pg. 4. Agency form.

INTERVIEWS:
Administrative (Human Resources) Staff.

FINDINGS
Agency Policy AS-203, Section III (F) (6), Pg. 4, and the agency's form, address this provision. The auditor interviewed the Administrative (Human Resources) Staff. Staff reported, although sexual harassment is harder to detect, the agency has incorporated and implemented the "Affirmative Duty to Disclose," which all staff were required to affirm and sign. The form provides for a "material omissions" clause.

115.317(c)
POLICY AND DOCUMENT REVIEW:
Agency policy AS-203, Section III (F) (5) and (F) (7), Pg. 4. Ten randomly selected staff HR files.

INTERVIEWS:
Administrative (Human Resources) Staff.

FINDINGS
Agency policy AS-203, Section III (F) (5) and (F) (7), Pg. 4, address this provision. A review of 8 randomly selected staff HR files indicated timely criminal background checks, and child abuse registry checks, all within the past two years. The auditor interviewed the Administrative (Human Resources) Staff. Staff reported criminal background records and child abuse registry checks are conducted on all new hires. Additionally, reference checks are conducted by contacting prior institutional employers.

115.317(d)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-203, Section III (F) (3) (f-i), Pgs. 3-4, and AS-209, Section I (B) (7), Pg. 2. HR Files.

INTERVIEWS:
The auditor interviewed the Administrative (Human Resources) Staff. Staff reported criminal background records and child abuse registry checks are conducted on all new hires and contractors.

FINDINGS
Agency Policies AS-203, Section III (F) (3) (f-i), Pgs. 3-4, and AS-209, Section I (B) (7), Pg. 2, addresses the elements of this provision. Agency policy defines staff to include interns, volunteer or contracted program services staff. All staff are also subjected to a criminal history background and child abuse registry checks. The agency contracts with the Austin Independent School District (AISD) for education services. AISD contract staff are subjected to a criminal background check, including a fingerprint based background check. AISD provided the agency with a list of teachers that had been vetted through its system and approved for assignment to the Juvenile Facilities. The agency reported they have 25 contract staff, and that AISD provides 26 contract teachers. A review of 8 randomly selected staff, volunteer and contract staff HR files indicated timely criminal background checks and subsequent criminal background checks. A review of seven (7) contract teacher HR files indicated timely child abuse registry checks were conducted.

Additionally, the auditor, who is a contractor, was required to and complied with the required criminal history background and child abuse registry check. The auditor requested and was provided with documentation reflecting the criminal history background and child abuse registry checks were conducted and completed prior to her arrival at the facility for the onsite audit. The auditor interviewed the Administrative (Human Resources) Staff. Staff reported criminal background records and child abuse registry checks are conducted on all new hires and contractors.

115.317(e)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-203, Section III (D) (4) and (D) (7), Pg. 2. Eight randomly selected staff and contract staff HR files.

INTERVIEWS:
Administrative (Human Resources) Staff.

FINDINGS
Agency Policy AS-203, Section III (D) (4) and (D) (7), Pg. 2, addresses this provision. Agency policy requires criminal history and child abuse registry checks will be conducted every two (2) years for certified officers and at least every five (5) years for non-certified staff contractors, interns and volunteers. A review of 8 randomly selected staff and contract staff HR files indicated timely criminal background checks, all completed within the past two years. Additionally, the agency, as all other juvenile probation departments, participates in the Fingerprint Applicant Services of Texas (FAST) system. The FAST system is designed to alert the agency when any employee, contractor, volunteer, or intern is arrested for any reason. All staff are provided the opportunity to self-disclose their arrest to their respective supervisor prior to the agency being provided the automatic notification. The auditor interviewed the Administrative (Human Resources) Staff. Staff reported, criminal background records and child abuse registry checks are subsequently conducted on all new hires every two (2) years and every year or biannually for contractors, although the longest a contractor can go without a new background check is three (3) years. Staff reported all certified officers are subject to the two-year criminal background checks. Staff that are not certified are required to undergo a background check upon promotion. Staff reported the agency is notified via the FAST system anytime any of their enrolled staff, including contractors and volunteers, are arrested. Staff reported AISD, per MOU, assign staff that have undergone a criminal history background check, which includes a finger-print based criminal history check, prior to assigning staff to the juvenile facility. A review of the agency policy and HR files, and staff interview indicate the agency has conducted criminal background records and child abuse registry checks on all staff every two (2) years and every year or biannually for contractors, which exceeds the five year minimum required by this provision of this standard.

115.317(f)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-203, Section III (F) (1), Pg. 3. HR Files.

INTERVIEWS:
Administrative (Human Resources) Staff.

FINDINGS
Agency Policy AS-203, Section III (F) (1), Pg. 3, addresses this provision. The application process includes the "Affirmative Duty to Disclose" form, for new hires, volunteers and contractors, and a review of the HR files indicated this process was being implemented. All staff HR files reviewed indicated the forms had been signed by the end of February 2016. The auditor interviewed the Administrative (Human Resources) Staff. Staff reported this process was implemented on January 2016 and all staff had already signed the forms, which were filed in each employees' HR file. A review of agency policy and HR files, and staff interview, indicate the practice is in place and meets the requirements of this provision.

115.317(g)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-203, Section III (F) (1), Pg. 3, and AS-209, Section I (B) (11), Pg. 3.

FINDINGS
Agency Policies AS-203, Section III (F) (1), Pg. 3, and AS-209, Section I (B) (11), Pg. 3, address this provision. Agency policy defines staff to include interns, volunteer or contracted program services staff.

115.317(h)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-203, Section III (F) (7) (c), Pg. 4. and AS-904, Section III (D) (3), Pg. 3.

INTERVIEWS:
Administrative (Human Resources) Staff.

FINDINGS
Agency Policies AS-203, Section III (F) (7) (c), Pg. 4. and AS-904, Section III (D) (3), Pg. 3, address this provision. The auditor interviewed the Administrative (Human Resources) Staff. Staff reported if the new potential employer secures a release form from the former employee, then the information will be released. Staff reported without the release form, HR will not disclose the information.

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.

115.318(a)
POLICY AND DOCUMENT REVIEW:
The agency reported it has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012.

FINDINGS
This provision is not applicable as the agency reported it has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012

115.318(b)
POLICY AND DOCUMENT REVIEW:
The agency reported it has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012.

FINDINGS
This provision is not applicable as the agency reported it has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012. The auditor noted a minimal number of cameras throughout the facility. The agency presented documented ongoing efforts to identify the business and technical requirements necessary for the upgrade of the facility. The agency's staffing plan reflects the enhanced technology will augment the staff supervision and enhance the sexual safety of the residents. The department will continue to prioritize the video surveillance system project. The scope of this project includes ensuring that the cameras added provide the most comprehensive coverage technology can allow, ensuring that the potential blind spots are covered. As an interim measure, facility representatives walked through their respective areas and provided recommendations to add security mirrors to priority areas to enhance supervision.

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.

115.321(a)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-901, Section III (C) (1), Pg. 5; AS-904, Section III (B), Pg. 2, (D), Pgs. 2-3, (E), Pgs. 3-4; AS-217, Section I, Pg. 1; and AS-217B, Section I, Pg. 1, Section III (D) (2), Pg. 3. The agency reported it oversees administrative investigations and the Travis County Sheriff's Office oversees the criminal investigations.

INTERVIEWS:
Random Sample of Staff.

FINDINGS
Agency Policies AS-901, Section III (C) (1), Pg. 5; AS-904, Section III (B), Pg. 2, (D), Pgs. 2-3, (E), Pgs. 3-4; AS-217, Section I, Pg. 1; and AS-217B, Section I, Pg. 1, Section III (D) (2), Pg. 3, address this provision. Staff interviewed indicated a clear knowledge of their responsibilities as potential first responders and knowledge of agency policy and staff roles and responsibilities pertaining to investigations of allegations of sexual abuse.. Each named of at least one (1) investigator they would report the incident to.

115.321(b)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-905, Section III (B) (1) (b), Pg. 3. Agency email communication.

FINDINGS
Agency Policy AS-905, Section III (B) (1) (b), Pg. 3, addresses this provision. The agency provided email communication, dated February 29, 2016, from a representative from Seton Hospital who reported the facility uses the Sexual Assault Nurse Examiner (SANE) protocol that was provided to them by the Texas Office of the Attorney General. A separate email dated March 16, 2016, from a representative from SafePlace indicated their protocol is in compliance with the Department of Justice and they have a working relationship with the Travis County Sheriff's Office when criminal investigations are initiated. A review of the agency policy and supporting documentation indicated the agency coordinates and ensures the protocol implemented is appropriate to the age of its residents and in compliance with this provision.

115.321(c)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-905, Section III (A-B) (2-3), Pgs. 1-2. Memorandum of Understanding (MOU) with SafePlace - Travis County Domestic Violence and Sexual Assault Survival Center. The agency reported there have been no forensic examinations conducted within the past 12 months. The agency reported there was one allegation of youth on youth abusive sexual contact over clothing, therefore there was no forensic evidence that could be collected.

INTERVIEWS:
SAFE/SANE Staff

FINDINGS
Although policy is not required, Agency Policy AS-905, Section III (A-B) (2-3), Pgs. 1-2, addresses this provision. The agency entered into a Memorandum of Understanding (MOU) with SafePlace - Travis County Domestic Violence and Sexual Assault Survival Center on September 8, 2014, to provide confidential victim advocacy services. A licensed Department counselor (LPC, LMSW, etc.) would be made available to accompany the resident through the forensic exam and investigative interviews only upon request from the resident. The agency has Dell Children's Hospital and Seton Hospital as options in response to this provision. The auditor interviewed a representative from SafePlace. The SafePlace representative reported being aware of the MOU in place with the department and if a forensic exam were to ever be required the proper protocol would be used depending on the age of the resident. The representative reported forensic exam nurses are available 24/7 and would triage a case and respond accordingly based on the age of the resident. A review of the agency policy, MOU agreement with SafePlace, and email communication with a hospital representative, and an interview with SANE/SAFE staff indicate the agency has secured local confidential victim advocacy resources needed in response to this provision.

115.321(d)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-905, Section III (C) (2), Pgs. 3. Memorandum of Understanding (MOU) with SafePlace - Travis County Domestic Violence and Sexual Assault Survival Center.

INTERVIEWS:
PREA Compliance Manager. Resident who reported a sexual abuse.

FINDINGS
Although policy is not required, Agency Policy AS-905, Section III (C) (2), Pgs. 3, addresses this provision. The agency entered into a Memorandum of Understanding (MOU) with SafePlace - Travis County Domestic Violence and Sexual Assault Survival Center on September 8, 2014, to provide confidential victim advocacy services. A licensed Department counselor (LPC, LMSW, etc.) would be made available to accompany the resident through the forensic exam and investigative interviews only upon request from the resident. The auditor interviewed the PREA Compliance Manager, who reported an MOU has been entered with SafePlace to help a resident through the process and they follow the DOJ protocols. The MOU includes the responsibilities the agency and provider are to follow, and the contract is monitored once a year. A review of the agency policy, MOU, and staff interview indicated an established collaborative effort to ensure victim advocacy services are available for the residents if needed. The resident interviewed reported the abuse involved sexual contact over clothing. The resident reported at the time of the incident he did not want any services, although he was provided the opportunity to access services by staff. He reported since the incident he has sought and received counseling from a therapist.

115.321(e)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-905, Section III (E) (1), Pgs. 4. Memorandum of Understanding (MOU) with SafePlace - Travis County Domestic Violence and Sexual Assault Survival Center. The agency reported there have been no forensic examinations conducted within the past 12 months.

INTERVIEWS:
PREA Compliance Manager. Resident who reported a sexual abuse.

FINDINGS
Although policy is not required, Agency Policy AS-905, Section III (E) (1), Pgs. 4, addresses this provision. The agency entered into a Memorandum of Understanding (MOU) with SafePlace - Travis County Domestic Violence and Sexual Assault Survival Center on September 8, 2014, to provide confidential victim advocacy services. A licensed Department counselor (LPC, LMSW, etc.) would be made available to accompany the resident through the forensic exam and investigative interviews only upon request from the resident. The auditor interviewed the PREA Compliance Manager who reported SafePlace would be contacted and staff would remain with the resident until the SafePlace advocate arrives. A review of the agency policy, MOU, and staff interview indicated an established collaborative effort to ensure victim advocacy services are available and would be provided to a

resident as needed. The resident interviewed reported the abuse involved sexual contact over clothing. The resident reported at the time of the incident he did not want any services, although he was provided the opportunity to access services by staff. He reported since the incident he has sought and received counseling from a therapist.

115.321(f)
POLICY AND DOCUMENT REVIEW:
Email documentation with the Travis County Sheriff's Office.

FINDINGS
The agency provided email documentation reflecting communication with a representative with the Travis County Sheriff's Office requesting the investigative agency follow the protocols for investigations as required by this provision. A review of the email communication between the agency and the investigative agency reflected compliance with this provision.

115.321(g)
POLICY AND DOCUMENT REVIEW:
The agency is not required to respond to this provision.

FINDINGS
This provision is not applicable as the agency is not required to respond to this provision.

115.321(h)
POLICY AND DOCUMENT REVIEW:
The agency is not required to respond to this provision.

FINDINGS
This provision is not applicable as the agency is not required to respond to this provision.

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.

115.322(a)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-217, Section I, Pg. 5; AS-901, Section I, Pg. 1; and AS-904, Section III(B), Pg. 2. The agency reported it oversees administrative investigations and the Travis County Sheriff's Office oversees the criminal investigations. Investigative File.

INTERVIEWS:
Chief Juvenile Probation Officer

FINDINGS
Agency Policies AS-217, Section I, Pg. 5; AS-901, Section I, Pg. 1; and AS-904, Section III(B), Pg. 2, address this provision. A review of the investigative file reflects the investigation was closed due to the alleged perpetrator being deported within two days of the date of the incident.
The auditor interviewed the Chief Juvenile Probation Officer, who reported once an allegation is made, an internal investigator is assigned to the case within hours if not sooner. The investigative process is initiated, and the agency's General Counsel oversees the investigations. The law enforcement agency would be notified within an hour and a report would be made to TJJD. Depending on the finding, the agency's investigative report may be shared with law enforcement and the agency would cooperate with the law enforcement agency. The investigative report is always referred to TJJD for review by an outside and independent agency. The Chief Juvenile Probation Officer reported the same process would be used for all investigations and the investigations would be done thoroughly. A review of the agency policies and investigative file, and staff interview indicated investigations are completed for all allegations of sexual abuse and sexual harassment.

115.322(b)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-901, Section III (A) (3), Pg. 3 and (C) (1), Pg. 5. The agency reported it oversees administrative investigations and the Travis County

Sheriff's Office oversees the criminal investigations. Agency's policy on the agency's website.

INTERVIEWS:
Investigative staff.

FINDINGS
Agency Policy AS-901, Section III (A) (3), Pg. 3 and (C) (1), Pg. 5, addresses this provision. A review of the agency policies and investigative file, and staff interview indicated criminal investigations are conducted by the Travis County Sheriff's Office and administrative investigations are the responsibility of the agency. The agency's policy in response to this provision are posted on the agency's website. A data base for tracking investigations is maintained. Any allegations reported to the TJJD by a resident activates an alert for the PREA Coordinator. The TJJD sends a separate alert to the Director of Residential Services for a follow-up investigation. For any abuse, neglect, or exploitation allegation received by TJJD, the TJJD will send the allegation and related information to the agency for follow-up within the prescribed time frame. TJJD initiates status checks on investigations on a monthly basis, and annually, reconciles incidents with the status progress of the investigation. The PREA Coordinator, the Agency's General Counsel and the Agency's Assistant Chief have secure access to the data base. Investigative staff interviewed reported the Travis County Sheriff's Office is responsible for criminal investigations, and the agency is responsible for administrative investigations.

115.322(c)
POLICY AND DOCUMENT REVIEW:
Agency's policy posted on the agency's website.

FINDINGS
The agency's policy is posted on the agency's website in accordance with this provision.

115.322(d)
POLICY AND DOCUMENT REVIEW:
The agency is not required to respond to this provision.

FINDINGS
This provision is not applicable as the agency is not required to respond to this provision.

115.322(e)
POLICY AND DOCUMENT REVIEW:
The agency is not required to respond to this provision.

FINDINGS
This provision is not applicable as the agency is not required to respond to this provision.

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.

115.331(a)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-902, Section III (C), Pg. 3; AS-401, Section III (F), Pg. 10-11. Agency curriculum. Six randomly selected staff training records.

INTERVIEWS:
Random Sample of Staff

FINDINGS
Agency Policies AS-902, Section III (C), Pg. 3; AS-401, Section III (F), Pg. 10-11, address this provision. A review of the agency policy, training curriculum, training records, and staff interviews demonstrate PREA related training is conducted and staff attend, participate and complete the training. The agency policy and curriculum address all the required topics. The auditor interviewed a total of 16 randomly selected staff. Of the sixteen interviewed, seven were assigned to the pre-adjudication facility and nine were assigned to the post-adjudication facility at the time of the onsite audit.

The PREA Coordinator reported staff are shared between the pre and post-adjudication facilities. Staff interviewed acknowledged attending and participating in the PREA training and confirmed the required topics were covered during the training. The staff interviewed reported receiving training in all the required topics within the past year.

115.331(b)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-401.

FINDINGS
Agency Policy AS-401 addresses this provision. The facility is a pre-adjudication secure facility, therefore all Juvenile Supervision Officers are trained to work with all residents in the facility. Staff reported everyone gets the exact same training regardless of working with males or females for the pre and post-adjudication facilities. Staff are trained to work in both pre and post-adjudication facilities.

115.331(c)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-401, Section III (F) (5), Pgs. 10-11. The agency reported all of their staff (100%) who have contact with residents are trained on the PREA topic requirements. Six randomly selected employee training records.

FINDINGS
Agency Policy AS-401, Section III (F) (5), Pgs. 10-11, addresses this provision. Agency policy requires staff receive PREA related training during orientation and on an annual basis. The auditor reviewed six (6) randomly selected employee training records. A review of the randomly selected employee training records reflected all had participated and completed the required PREA training. Additionally, Agency Policy AS-401, Section III (F) (2) (b), Pg. 6, requires all Juvenile Probation Officers (JPOs) to be trained on the same PREA topics as Juvenile Supervision Officers. Policy requires the JPOs to complete this training during orientation. Training documentation reviewed supported the participation of JPOs, as well as participation by management and administrative support staff, in the PREA training.

115.331(d)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-401, Section III (G), Pg. 12. PREA Standard 115.331 (a) Training Acknowledgement Form.

FINDINGS
Agency Policy AS-401, Section III (G), Pg 12 addresses this provision. The agency maintains the signed acknowledgement forms which affirm the trainees understand the training they have received. Through staff interviews, it was made clear to the auditor that the staff understood the PREA training.

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.

115.332(a)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-1001, Section III (D) (7), Pg. 3, and (E), Pg. 5. Volunteer/Intern Handbook 2016. Volunteer, intern, and contract staff training documentation, which included three randomly selected training files, sign-in sheets, signed acknowledgement forms, and Certificates of Completion for medical and mental health staff. The agency reported having 40 volunteers and contractors that have contact with residents.

INTERVIEWS:
Volunteers and Contractors.

FINDINGS
Although not required, Agency Policy AS-1001, Section III (D) (7), Pg. 3, and (E), Pg. 5 addresses volunteer and intern training. The Volunteer/Intern Handbook 2016, and volunteer and contract staff training documentation was reviewed. Training documentation reflected training events held specifically for mental health and school contract staff and volunteers/interns. The auditor interviewed five randomly selected volunteers and contractors. One of the volunteers also volunteers at the pre-adjudication facility and one of the contractors also works at the pre-adjudication facility. The volunteers and contract staff interviewed reported being trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection and

response policies and procedures.

115.332(b)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-1001, Section III (E) (3), Pg. 5. Volunteer/Intern Handbook 2016.

INTERVIEWS:
Volunteers and contractors.

FINDINGS
Although not required, Agency Policy AS-1001, Section III (E) (3), Pg. 5, addresses volunteer and intern training. The agency's Volunteer/Intern Handbook 2016 addresses the zero tolerance policy on page 29. Training documentation reflected training events held specifically for mental health and school contract staff and volunteers/interns. The auditor interviewed five randomly selected volunteers and contractors. One of the volunteers also volunteers at the pre-adjudication facility and one of the contractors also works at the pre-adjudication facility. The volunteers and contract staff interviewed reported being trained on the agency's zero tolerance policy regarding sexual abuse and sexual harassment and of the reporting requirements.

115.332(c)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-1001, Section III (A) (5 and 8), Pg. 2. Signed Volunteer/Intern and Contractor Acknowledgement Forms.

FINDINGS
Although not required, Agency Policy AS-1001, Section III (A) (5 and 8), Pg. 2, addresses volunteer and intern training. The acknowledgment forms contained the proper affirmation statement. Through interviews, it was made clear the volunteers and contract staff understood the PREA training.

Standard 115.333 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.333(a)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-1203, Section III (E) (1), Pg. 4, and (G) (3) (b), Pg. 6; AS-902, Section III (G) (2), Pg. 5. Resident Handbook (English and Spanish). Brochures (English and Spanish). Eleven randomly selected case files. The agency reported 118 residents were admitted and provided with the required PREA information at intake during the past 12 months.

INTERVIEWS:
Intake Staff. Randomly selected residents.

FINDINGS
Although not required, Agency Policies AS-1203, Section III (E) (1), Pg. 4, and (G) (3) (b), Pg. 6; AS-902, Section III (G) (2), Pg. 5, address this provision. A review of 11 case files reflected all residents were provided the initial education required on the same day during intake. The intake staff reported the orientation packet contains all the PREA related information which is provided to all the residents during the intake process. Staff reported information on the zero tolerance policy and how to report allegations are also contained on posters, which are posted throughout the facility, and that the PREA information is presented again on weekends to the groups in the housing units. Residents interviewed reported being provided the PREA information during intake and already being aware of the information because they also received it while placed at the pre-adjudication facility.

115.333(b)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-902, Section III (G) (3), Pg. 6. Eleven case files.

INTERVIEWS:
Intake Staff. Randomly selected residents.

FINDINGS

Although not required, Agency Policy AS-902, Section III (G) (3), Pg. 6, addresses this provision. A review of 11 case files reflected six (6) residents were not provided the comprehensive education within 10 days of intake. As soon as the agency leadership was advised of this finding, corrective action was implemented immediately to ensure residents would receive the comprehensive education within 10 days. The auditor recommended all residents be provided comprehensive education specific to PREA. The auditor noted the agency implemented immediate corrective action during the initial onsite visit. It was agreed a follow-up onsite visit would be conducted to ensure the practice had been fully implemented. A follow-up onsite visit was conducted as part of the post-audit phase. Residents are provided the PREA education and comprehensive information during intake and orientation. Subsequently, on a monthly bases, a PREA education video is presented to the residents. Completed sign-in sheets reflecting the names of residents are maintained for documentation purposes, and a staff person was assigned to oversee this specific task to ensure compliance is maintained at all times. Subsequent staff and resident interviews indicated the practice had been implemented.

115.333(c)
POLICY AND DOCUMENT REVIEW:
Agency's Policy AS-902, Section III (G), Pg. 6.   Eleven case files.

INTERVIEWS:
Intake Staff.

FINDINGS
Agency's Policy AS-902, Section III (G), Pg. 6, addresses this provision.   A review of 11 case files reflected all residents had been provided the required PREA related information and education. Staff interviewed reported the information is provided during intake and orientation. Staff reported they use the PREA Notebooks as part of the educational materials for the residents.

115.333(d)
POLICY AND DOCUMENT REVIEW:
Agency's Policy AS-902, Section III (G) (3) (b), Pg. 6.   Resident Handbook, PREA brochures, and PREA posters. Interpreter Services for Deaf & Hard of Hearing Brochure.

FINDINGS
Agency's Policy AS-902, Section III (G) (3) (b), Pg. 6, addresses this provision.   PREA related information and education materials provided in English and Spanish include the Resident Handbook, PREA brochures, and PREA posters. The Resident Handbook is available to the residents in each housing unit. PREA posters, English and Spanish, are posted throughout the facility and in each housing unit. An informational brochure for Interpreter Services for Deaf & Hard of Hearing provides staff with information on how to secure interpretation services for deaf and hard of hearing residents. Multiple staff can also translate in Spanish

115.333(e)
POLICY AND DOCUMENT REVIEW:
Agency's Policy AS-902, Section III (G) (3) (b), Pg. 6. Eleven case files. The Acknowledgement of Receipt of Orientation Information and Materials Form and the Detention Services PREA Group Sign in Sheet

FINDINGS
Although not required, Agency's Policy AS-902, Section III (G) (3) (b), Pg. 6, addresses this provision.   A review of 11 case files reflected all residents had been provided the required PREA related information and education. The completed Acknowledgement of Receipt of Orientation Information and Materials Form is used to document when residents are provided the PREA information at intake. The completed "PREA: What You Need to Know: Resident Education Form" is used to document the names of the residents that participate in the subsequent monthly PREA education classes.

115.333(f)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-902, Section III (G) (3)(a), Pg. 6.

ONSITE REVIEW (TOUR OBSERVATIONS):
PREA educational and informational materials, including the Resident Handbook and PREA posters are available in each respective housing unit.

FINDINGS
Although not required, Agency Policy AS-902, Section III (G) (3) (a), Pg. 6, addresses this provision. PREA educational and informational materials, including the Resident Handbook and PREA posters are continuouesly available in each respective housing unit.

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.

115.334(a)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-217B, Section III (C), Pg. 2. Training documentation: faculty bios, training agenda, training modules, and PREA general and specialized investigator training records sign-in sheets

INTERVIEWS:
Investigative Staff was interviewed.

FINDINGS
Agency Policy AS-217B, Section III (C), Pg. 2, addresses this provision. Staff interviewed reported receiving the required investigative training in 2013 during a two and a half day training event from the Moss Group. Training documentation reflected the investigators had completed the general PREA training and the specialized investigator training.

115.334(b)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-217B, Section III (C) (2), Pg. 2. Training Modules,

INTERVIEWS:
Investigative Staff was interviewed.

FINDINGS
Agency Policy AS-217B, Section III (C) (2), Pg. 2. addresses this provision. The training module included all of the required topics. Staff interviewed reported receiving training on each of the required topics.

115.334(c)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-401, Section III (G), Pg. 12. Training records: Sign-in Sheets. The agency reported there are five staff trained to conduct administrative investigations.

FINDINGS
Although not required, Agency Policy AS-401, Section III (G), Pg. 12. addresses this provision. A review of the specialized training sign-in sheets reflect all five investigators had completed the required training. A review of an investigative file reflected a former employee had conducted the investigations. Training documentation reflected the investigator was trained on the specialized investigator training.

115.334(d)
POLICY AND DOCUMENT REVIEW:
The agency is not required to respond to this provision.

FINDINGS
This provision is not applicable as the agency is not required to respond to this provision.

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.

115.335(a)

POLICY AND DOCUMENT REVIEW:
Agency Policy AS-401, Section III (F) (3) (c) (2), Pg. 9. Training records: randomly selected training files, sign-in sheets, and Certificates of Completion.

INTERVIEWS:
Medical and Mental Health Staff

FINDINGS
Agency Policy AS-401, Section III (F) (3) (c) (2), Pg. 9, addresses this provision. Training documentation reviewed indicated medical and mental health staff participated in the specialized medical and mental health PREA training.

115.335(b)
POLICY AND DOCUMENT REVIEW:
The agency reported the facility's medical staff do not conduct forensic exams, therefore this provision is not applicable.

INTERVIEWS:
Medical Staff

FINDINGS
The agency reported the facility's medical staff do not conduct forensic exams, therefore this provision is not applicable. Medical staff interviewed confirmed they do not conduct forensic exams onsite and that SafePlace provides that service if needed.

115.335(c)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-401, Section III (G), Pg. 12. Training records: randomly selected training files, sign-in sheets, and Certificates of Completion.

FINDINGS
Although not required, Agency Policy AS-401, Section III (G), Pg. 12, addresses this provision. Training documentation reviewed indicated medical and mental health staff, including contract staff, participated in the general and specialized PREA training. Training documentation reflected some of the training was secured in-house as well via online coursework though the National Institute of Corrections (NIC).

115.335(d)
POLICY AND DOCUMENT REVIEW:
Training records: randomly selected training files, sign-in sheets, and Certificates of Completion.

FINDINGS
Training documentation reviewed reflected medical and mental health staff, including contract staff, participated in the general PREA training.

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.

115.341(a)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-902, Section III (G) (3) (c), Pg. 6, and RS-1.35, Section II(F), Pg. 2, and Section III(D), Pgs. 3-4. Eleven randomly selected resident files.

INTERVIEWS:
Staff responsible for risk screening: intake and medical staff, and randomly selected residents.

FINDINGS
Agency Policies AS-902, Section III (G) (3) (c), Pg. 6, and RS-1.35, Section II(F), Pg. 2, and Section III(D), Pgs. 3-4, address this provision.
Eleven juvenile files were reviewed. Ten of the case files reflected the screening process was completed on the same date of arrival. The eleventh file

reflected the screening process was completed on the following day after arrival at the facility. Staff interviewed reported residents are screened normally within two hours and that they would continue to do follow-up with a resident periodically. Staff reported if any risk factors were to be detected, the resident would be referred to the appropriate staff for proper follow-up and reclassification if needed. Residents interviewed verified staff do conduct periodic follow-up questions after the intake process is completed. Some residents reported being seen by medical or mental health staff subsequently, after the follow-up questions, which was based on the information staff secured and indicated an appropriate agency response based on the new information provided by the residents. Based on staff interviews and the review of resident case files, it was determined the initial risk screening process is completed well within the 72-hour requirement.

115.341(b)
POLICY AND DOCUMENT REVIEW:
The agency used two objective screening instruments: Residential Housing Screening Form and Residential Housing Screener Review Form.

FINDINGS
The agency used two objective screening instruments: Residential Housing Screening Form and Residential Housing Screener Review Form for follow-up reassessments.

115.341(c)
POLICY AND DOCUMENT REVIEW:
The agency's Residential Housing Screening Form and Residential Housing Screener Review Form.

INTERVIEWS:
Staff responsible for risk screening: intake and medical staff

FINDINGS
The agency's Residential Housing Screening Form and Residential Housing Screener Review Form reflect all the required elements in the provision. Staff interviewed confirmed they use the agency's screening tools during intake. Staff interviewed properly referenced the required elements residents are screened for during the risk screening process.

115.341(d)
INTERVIEWS:
Staff responsible for risk screening: intake and medical staff.

FINDINGS
Staff reported the information is ascertained through resident and parent interviews, and from information collected through the MAYSI Screening tool, medical screening, and case file records.

115.341e)
INTERVIEWS:
PREA Coordinator, PREA Compliance Manager, and staff responsible for risk screening: intake and medical staff

FINDINGS
Intake staff interviewed reported they do not have access to the resident's medical or mental health information. Forms are in triplicate and color coded. The resident's medical information is retained and only available to medical staff. Staff reported line staff do not see a whole lot of information. The treatment files are retained in the counselor's offices. Staff reported the treatment modality drives which staff need the information.

Standard 115.342 Use of screening information

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.342(a)
POLICY AND DOCUMENT REVIEW:
Agency Policy RS-1.35, Section III(D), Pg. 3. Residential Housing Screening Form and Residential Housing Screener Review Form.

INTERVIEWS:
PREA Compliance Manager, and staff responsible for risk screening.

FINDINGS
Although not required, Agency Policy RS-1.35, Section III(D), Pg. 3, addresses this provision. The Residential Housing Screening Form and Residential Housing Screening Review Form reflect and document the housing assignment. Staff interviewed reported the information from the screener alerts staff to any past incidents or experiences and potential vulnerabilities. Staff then make assignments based on the programming and treatment needs of the resident and house residents as safely as possible.

115.342(b)
POLICY AND DOCUMENT REVIEW:
Agency Policy RS-5.100, Section III (H) (3), Pg. 15.

Division Director of Residential Services, Staff who Supervise Residents in Isolation, Medical and Mental Health Staff. There were no residents in isolation (for risk of sexual victimization/who allege to have suffered sexual abuse) at the time of the onsite audit, therefore no resident was interviewed specific to this provision.

ONSITE REVIEW (TOUR OBSERVATIONS):
During the tour, there was no indication that isolation is used on a regular basis.

FINDINGS
Although not required, Agency Policy RS-5.100, Section III (H) (3), Pg. 15, addresses this provision. The Dividsion Director reported residents are not isolated. Other staff reported the isolation of any resident has not occurred in a long time. Medical and mental health staff reported they would conduct daily visits for any residents placed in isolation.

115.342(c)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-1203, Section III (E), Pg. 4 and (E), Pg. 5. The agency reported there have not been any residents that have disclosed that they were transgender residents in the past 12 months.

INTERVIEWS:
PREA Coordinator, and PREA Compliance Manager. At the time of the onsite audit, there were no transgender residents housed at the facility, therefore no resident was interviewed specific to this provision.

FINDINGS
Agency Policy AS-1203, Section III (E), Pg. 4 and (E), Pg. 5, addresses this provision. Staff interviewed reported the facility does not have special housing units designated for lesbian, gay, bisexual, transgender, or intersex residents.

115.342(d)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-1203, Section III (F) (1) and (F) (3), Pg. 5.

INTERVIEWS:
PREA Compliance Manager. At the time of the onsite audit, there were no transgender/intersex residents housed at the facility, therefore no resident was interviewed specific to this provision.

FINDINGS
Agency Policy AS-1203, Section III (F) (1) and (F) (3), Pg. 5, addresses this provision. Staff interviewed reported they would take into consideration the resident's own views, plus have the treatment team review and consider the case before a decision would be made. The PREA Compliance Manager reported every effort would be made to keep the residents safe and secure.

115.342(e)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-1203, Section III (F) (6), Pg. 6. The agency reported there have not been any residents that have disclosed that they were transgender residents in the past 12 months.

INTERVIEWS:
PREA Compliance Manager, and staff responsible for risk screening.

FINDINGS
Although not required, Agency Policy AS-1203, Section III (F) (6), Pg. 6, partially addresses this provision. Staff interviewed reported the resident's health and safety are taken into consideration during placement and programming assignments.

115.342(f)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-1203, Section III (F) (4), Pg. 5.

INTERVIEWS:
PREA Compliance Manager, and staff responsible for risk screening. At the time of the onsite audit, there were no transgender/intersex residents housed at the facility, therefore no resident was interviewed specific to this provision.

FINDINGS
Agency Policy AS-1203, Section III (F) (4), Pg. 5, addresses this provision. Staff interviewed reported they would take into consideration the resident's own views with respect to his or her own safety.

115.342(g)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-1203, Section III (G), Pg. 6.

INTERVIEWS:
PREA Compliance Manager, and staff responsible for risk screening.

ONSITE REVIEW (TOUR OBSERVATIONS):
During the tour, the auditor noted the showers are designed to allow for single showering.

FINDINGS
Agency Policy AS-1203, Section III (G), Pg. 6, addresses this provision. The facility design allows for residents to shower one at a time. Staff interviewed reported all residents shower separately and that there are no communal showers.

115.342(h)
POLICY AND DOCUMENT REVIEW:
The agency reported there have been no PREA related incidents involving the isolation of any resident in the past 12 months.

FINDINGS
The agency reported there have been no PREA related incidents involving the isolation of any resident in the past 12 months, therefore there were no case files to review specific to this provision.

115.342(i)
POLICY AND DOCUMENT REVIEW:
Agency Policy RS-5.100, Section III (H) (4), Pg. 15-16. Staff reported no residents have been placed in isolation for PREA related risk factors in the past 12 months.

INTERVIEWS:
Staff who Supervise Residents in Isolation. There were no residents in isolation (for risk of sexual victimization/who allege to have suffered sexual abuse) at the time of the onsite audit, therefore no resident was interviewed specific to this provision.

FINDINGS
Agency Policy RS-5.100, Section III (H) (4), Pg. 15-16, addresses this provision. A review of the agency policy indicates a review by the Director of Residential Services to determine whether there is a continuing need for separation from the general population would occur if the isolation of the resident were to exceed 72 hours. This would far exceed the 30-day review required by this provision. Staff interviewed a review of residents in isolation would be done at each shift, plus medical and mental health staff would see the resident at least once a day. The auditor noted the agency policy exceeds this provision of the 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.

115.351(a)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-901, Section III (A) (1) (A, E), Pg. 3; and (E) (1) and (F), and Pg. 9. Resident Handbook. Grievance Form. Writing Instruments.

INTERVIEWS:
Random Sample of Staff and Random Sample of Residents.

ONSITE REVIEW (TOUR OBSERVATIONS):
During the tour, the auditor noted PREA Posters (noting the abuse hotline number), phones, and grievance forms are accessible to the residents in each housing unit and in common areas. The auditor tested the phones to ensure the hotline number worked. The call was answered by a representative.

FINDINGS
Although not required, Agency Policy AS-901, Section III (A) (1) (A, E), Pg. 3; and (E) (1) and (F), and Pg. 9, partially addresses this provision. Staff interviewed reported residents have several options available to report an allegation: grievance form; a letter; call the hotline number; tell staff (including a counselor, or supervisor), and his or her attorney or probation officer. Residents interviewed reported they could write a letter, file a grievance, make a report to staff (administration, director, supervisor, counselor); family, use the hotline, or their probation officer. Most of the residents indicated they would go directly to staff.

115.351(b)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-901, Section III (A) (2) (a) (4), Pg. 3; AS-902, Section III (G) (5), Pg. 6; and RS-2.50, Section III(A)(1)(a), Pg. 3.

INTERVIEWS:
PREA Compliance Manager, and Random Sample of Staff.

ONSITE REVIEW (TOUR OBSERVATIONS):
During the tour, the auditor noted PREA Posters (noting the abuse hotline to the Texas Department of Juvenile Justice-TJJD), and phones are accessible to the residents in each housing unit. The auditor tested the phones to ensure the hotline number worked. The call was answered by a hotline representative.

FINDINGS
Agency Policies AS-901, Section III (A) (2) (a) (4), Pg. 3; AS-902, Section III (G) (5), Pg. 6; and RS-2.50, Section III(A)(1)(a), Pg. 3, address this provision. Staff interviewed reported residents can call the hotline number or file a grievance. Residents interviewed reported they could write a letter, file a grievance, make a report to staff (administration, director, supervisor, counselor); family, use the hotline, or their probation officer. Most of the residents indicated they would go directly to staff. Agency policy states that residents are not detained solely for civil immigration purposes.

115.351(c)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-901, Section III (C) (4), Pg. 7; AS-903, Section III (A) (2), Pg. 3; and RS-2.50, Section III(A)(1), Pg. 3.

INTERVIEWS:
Random Sample of Staff and Random Sample of Residents. Staff interviewed reported they would accept reports in writing, file a grievance, anonymously, verbally and through third parties, and that any reports received verbally would be documented immediately. Staff added residents can also report staff neglect. Residents interviewed reported they could make reports anonymously, in writing, file a grievance, verbally, through a parent, staff member, counselor, or through their attorney. Residents reported they can also report retaliation.

115.351(d)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-901, Section III (A) (1) (A), Pg. 3; and RS-2.50, Section III(A)(1), Pg. 3.

INTERVIEWS:
PREA Compliance Manager. Resident who Reported a Sexual Abuse.

FINDINGS
Agency Policies AS-901, Section III (A) (1) (A), Pg. 3; and RS-2.50, Section III(A)(1), Pg. 3, address this provision. Staff interviewed reported residents can have the hotline information on the PREA posters and call the hotline, access to writing utensils, access to a grievance form. The grievance system allows for residents to submit a report confidentially and anonymously. Residents can also go to staff, including nursing staff, and their family can also notify the agency regarding any concern. The resident interviewed reported he went immediately to staff who provided him assistance with reporting the incident.

115.351(e)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-903, Section III (A) (3), Pg. 4; AS-401, Section III (F) (2 and 5), Pg. 10 and (E), Pg. 7.

INTERVIEWS:
Random Sample of Staff

FINDINGS
Agency Policies AS-903, Section III (A) (3), Pg. 4; AS-401, Section III (F) (2 and 5), Pg. 10 and (E), Pg. 7, address this provision. Staff interviewed reported they could privately report an incident by going directly to the Director or Chief, notify their supervisor, call the hotline or anonymously.

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.

115.352(a)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-901, Section III (A), Pg. 3; AS-904; and RS-6.160, Section III (E) (4) (b), Pg. 4-5.

FINDINGS
Agency Policies AS-901, Section III (A), Pg. 3; AS-904; and RS-6.160, Section I, Pg. 1, address this provision. Agency Policy AS-901 requires all allegations of abuse, including sexual abuse and sexual harassment, be reported. Policy requires allegations be reported to supervisory personnel, relevant agency (TJJD), or investigatory authority (Travis County Sheriff's Department, Austin Police Department, or Austin Independent School District Police Department). One reported, the allegation is investigated administratively and/or criminally. Agency Policy RS-6.160, Section III (E) (4) (b), Pg. 4-5, states, "All grievances that include allegations of abuse, neglect, or exploitation, to include sexual abuse and sexual harassment, will be resolved by indicating that the allegation will be investigated as outlined policy AS-217: Administrative Investigations." Agency policy and the Resident Handbook provide the grievance process as an option residents can utilize to report sexual abuse or sexual harassment allegations. Agency Policy AS-901, Section III (A) (2), States, "… There are no time limits for reporting allegations." The resident handbook does not put restrictions or timeframes by when any allegation may be reported.

Residents are informed of their right to access the grievance process during orientation. If a resident uses the grievance process system to inform the staff of any allegations of sexual abuse or sexual harassment, 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.

The agency reported there have not been any allegations of sexual abuse or sexual harassment submitted using the grievance process in the past 12 months. Additionally, there have not been any allegations of substantial risk of imminent sexual abuse during the same time frame. While residents are advised during the orientation process that charges may be filed for a false allegation, the Department has not pursued any criminal or civil charges during the past 12 months nor has it imposed any level of disciplinary action against a resident for filing a "bad faith" allegation.

Based on the review of agency policy and practice and staff interviews, primarily with the PREA Coordinator, the auditor determined the agency is exempt from this standard. The agency does provide the Grievance Process as an option for residents to report an allegation of sexual abuse or sexual harassment. Once such grievance is received, the grievance process ceases and the administrative/criminal investigative process is initiated. This being the practice, the agency demonstrated it no longer uses the administrative procedures to address resident grievances regarding sexual abuse or sexual harassment as it will for other grievances.

115.352(b-g)
POLICY AND DOCUMENT REVIEW:
115.352(a) finding.

FINDINGS
A review of provision 115.352(a) has determined the agency is exempt from this standard and subsequently provisions 115(b-g) of this standard. The provisions of this standard are not applicable.

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.

115.353(a)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-905, Section III (E), Pg. 4. Posted SafePlace information.

INTERVIEWS:
Random Sample of Residents. Resident who Reported a Sexual Abuse.

ONSITE REVIEW (TOUR OBSERVATIONS):
During the tour, the auditor noted the posted SafePlace information in every housing unit. The information includes information on the emotional support and counseling services SafePlace provides, access for the Deaf community and interpretation services for those who speak other languages. The hotline number is posted as well as 24/7 availability by SafePlace. SafePlace informational brochures are available for the residents in English and Spanish.

FINDINGS
Agency Policy AS-905, Section III (E), Pg. 4, addresses this provision. All but one of the residents interviewed reported they had never reported an incident of sexual abuse while at the facility. The resident interviewed reported he immediately notified a staff member, who then provided him assistance with reporting the incident via the hotline. He added that at the time of the incident he did not want any services, but since then he has requested and met with a therapist. He added he is aware and can request outside services.

115.353(b)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-905, Section III (E) (4), Pg. 4.

INTERVIEWS:
Random Sample of Residents. Resident who Reported a Sexual Abuse.

FINDINGS
Agency Policy AS-905, Section III (E) (4), Pg. 4, addresses this provision. All but one of the residents interviewed reported they had never reported an incident of sexual abuse while at the facility. The resident interviewed reported he is aware of outside services and accessed a therapist plus the unit counselors.

115.353(c)
POLICY AND DOCUMENT REVIEW:
Memorandum of Understanding with SafePlace

FINDINGS
The Memorandum of Understanding (MOU) with SafePlace was signed on 9-8-14.

115.353(d)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-901, Section III (A) (1) (a) (3), Pg. 3; RS-6.180, Sections I, and III(C), Pg. 1; RS-6.210, Sections I, Pg. 1, and III(B)(5), Pg. 2; and RS-6.220, Sections II(A), Pg. 1, III(A-B), Pgs. 2-3.

INTERVIEWS:
Division Director of Residential Services, and PREA Compliance Manager. Random Sample of Residents. Resident who Reported a Sexual Abuse.

FINDINGS
Agency Policies AS-901, Section III (A) (1) (a) (3), Pg. 3; RS-6.180, Sections I, and III(C), Pg. 1; RS-6.210, Sections I, Pg. 1, and III(B)(5), Pg. 2; and RS-6.220, Sections II(A), Pg. 1, III(A-B), Pgs. 2-3, address this provision. Staff interviewed reported residents can see their attorney anytime, and have contact with their parents by phone once a week based on the behavior management system, or through visitation. Staff reported if residents act out, they are placed on time out and the parent is notified and the situation is explained to the parent. All but one of the residents interviewed reported they can visit with their attorneys and their communication is confidential. They also reported they can call and/or visit with their parents. Some of the residents reported they get to see their parents as part of group and/or individual sessions. The resident interviewed reported he can speak with his attorney at any time and that his attorney is aware of the incident. One resident reported he is on restriction and can't visit and his Dad knows about it.

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.

115.354(a)
POLICY AND DOCUMENT REVIEW:
Although not required, Agency Policy AS-901, Section III (A) (1), Pg. 3. PREA Brochure

FINDINGS
Although not required, Agency Policy AS-901, Section III (A) (1), Pg. 3, addresses this provision. Third party reports can be received either in writing or verbally or through the TJJD. The PREA Brochure includes information on "Trustworthy Adults" that can help a resident with the reporting abuse. Trustworthy adults include a facility staff member, counselor, teacher, medical professional, attorney, probation officer, parent, guardian, or other family member.

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.

115.361(a)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-901, Section III (A) (1), Pg. 3, and (C) (1), Pg. 4; AS-904, Section III (G-H), Pg. 5; and AS-217, Section III (H), Pg. 3.

INTERVIEWS:
Random Sample of Staff

FINDINGS
Agency Policies AS-901, Section III (A) (1) , Pg. 3, and (C) (1), Pg. 4; AS-904, Section III (G-H), Pg. 5; and AS-217, Section III (H), Pg. 3, address this provision. All staff interviewed reported they would immediately report any knowledge, suspicion, or information regarding any allegation of sexual abuse or sexual harassment. Agencies they would make reports to include TJJD, DSHS, CPS and law enforcement. Staff would also report allegations to their supervisor immediately. Staff also reported they would report any retaliation against staff or residents who reported an incident or any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

115.361(b)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-901, Section III (A) (4), Pg. 3.

INTERVIEWS:
Random Sample of Staff

FINDINGS
Agency Policy AS-901, Section III (A) (4), Pg. 3, addresses this provision. All staff interviewed reported they are required to comply with the State's mandatory child abuse reporting laws.

115.361(c)

POLICY AND DOCUMENT REVIEW:
Agency Policy AS-901, Section III (A) (8) (a), Pg. 4.

INTERVIEWS:
Random Sample of Staff

FINDINGS
Agency Policy AS-901, Section III (A) (8) (a), Pg. 4, addresses this provision. Staff interviewed reported they would make the initial report to their supervisor, write the incident report, and thereafter wait for further instructions from their supervisor. Staff reported they would not discuss the case with anyone else.

115.361(d)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-901, Section II (B), Pg. 1, and Agency Policy AS-902, Section III (G) (1), Pg. 5.

INTERVIEWS:
Medical and Mental Health Staff.

FINDINGS
Agency Policies AS-901, Section II (B), Pg. 1, and Agency Policy AS-902, Section III (G) (1), Pg. 5, address this provision. Agency policy defines staff as a person hired to a position in the Department or an intern, volunteer, contracted programs services staff or other individuals working under the auspices of the Department. Staff interviewed reported they complete the Informed Consent Form with Residents 18+ years of age, and per policy are notified of the staff duty to report and the limitations of confidentiality when allegations of sexual abuse and sexual harassments are disclosed. With residents younger than 18 years of age, they are required to report allegations of sexual abuse to the appropriate agencies (law enforcement, TJJD, DFPS, and DSHS). Staff reported they were not aware of any incidents to date.

115.361(e)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-901.

INTERVIEWS:
Division Director of Residential Services
PREA Compliance Manager

FINDINGS
Agency Policy AS-901 addresses this provision. Staff interviewed reported in detail all the reporting requirements which included external agencies or individuals (law enforcement, TJJD, DSHS, prosecutor's office, child's attorney, and parent), and internal staff (upper management, and investigative), plus the required timeframes for reporting.

115.361(f)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-901, Section III (A).

INTERVIEWS:
Division Director of Residential Services

FINDINGS
Agency Policy AS-901, Section III (A) addresses this provision. Staff interviewed reported sexual abuse and sexual harassment allegations are reported directly to the facility's designated investigators.

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.

115.362(a)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-903, Section III (B), Pg. 4, and RS-2.50 and AS-903. The agency reported there had no reported instances of residents being subject to a substantial risk of imminent sexual abuse in the past 12 months.

INTERVIEWS:
Chief Juvenile Probation Officer, Division Director of Residential Services, and Random Sample of Staff.

FINDINGS
Agency Policies AS-903, Section III (B), Pg. 4, and RS-2.50 and AS-903, address this provision. Staff interviewed reported immediate action would be taken if staff were to become aware of any resident being at substantial risk of imminent sexual abuse. Staff reported any allegation would be taken seriously and due diligence would be followed to ensure staff respond to residents immediately. Management staff reported the alleged victim and alleged perpetrator would be separated immmediately. Residents could be reassigned to different housing units; allegations involving staff would result in staff being reassigned or being placed on administrative leave. An investigation would be immediately initiated. Randomly selected staff reported in detail the immediate steps they would take to respond to any allegation of a resident reporting they are at a substantial risk of imminent sexual abuse.

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.

115.363(a)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-901, Section III (D) (10), Pg. 9. The agency reported there had been no notification of any allegations that a resident was sexually abused or sexually harassed while confined at another facility.

FINDINGS
Agency Policy AS-901, Section III (D) (10), Pg. 9, addresses this provision.

115.363(b)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-901, Section III (D) (10), Pg. 9

FINDINGS
Agency Policy AS-901, Section III (D) (10), Pg. 9, addresses this provision.

115.363(c)
POLICY AND DOCUMENT REVIEW:
The agency reported there had been no notification of any allegations that a resident was sexually abused or sexually harassed while confined at another facility.

FINDINGS
The agency reported there had been no notification of any allegations that a resident was sexually abused or sexually harassed while confined at another facility, therefore there was no documentation to review. If any allegation is made, the notifications and documentation of the notifications would be made according to department policy.

115.363(d)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-217, Section I, Pg. 1. Staff reported there had been no notification from another facility of any allegation that a resident was sexually abused or sexually harassed while confined at the facility.

INTERVIEWS:
Chief Juvenile Probation Officer, and Division Director of Residential Services

FINDINGS
Agency Policy AS-217, Section I, Pg. 1, addresses this provision. Staff interviewed reported they would initiate an investigation just like any other. They would make a request for cooperation from the other facility, and staff would go visit the resident at that facility. Staff reported the Agency's General Counsel would oversee the investigative team and process.

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.

115.364(a)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-903, Section III (D-F), Pgs. 5-8, and RS-2.50, Section III (F), Pgs. 6-7.

INTERVIEWS:
Security Staff and Non-Security Staff First Responders. Resident who Reported a Sexual Abuse.

FINDINGS
Agency Policies AS-903, Section III (D-F), Pgs. 5-8, and RS-2.50, Section III (F) (1) (a), Pg. 6, addresses this provision. A review of the document titled, "First Responder Duties Residential Services Assess - Respond - Stabilize," outlines in detail the steps staff are to follow when responding to an allegation, including notification and documentation protocols. Staff interviewed outlined the response taken in response to an allegation. The agency protocol, which meets the standard requirements, was followed. The resident interviewed reported he alerted staff, who immediately began to assist him. The staff assisted him with calling the hotline number and within an hour a therapist arrived.

115.364(b)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-903, Section III (D) (5), Pg. 5, and (E) (3), Pg. 6; and RS-2.50, Section III (D) (5), and (E) (3), Pg. 3.

INTERVIEWS:
Security Staff and Non-Security Staff First Responders. The first responder was a certified Juvenile Supervision Officer, therefore there was no non-security staff first responder interviewed specific to this provision. Resident who Reported a Sexual Abuse.

FINDINGS
Agency Policies AS-903, Section III (D) (5), Pg. 5, and (E) (3), Pg. 6; and RS-2.50, Section III (D) (5), and (E) (3), Pg. 3, address this provision. Staff interviewed reported the incident involved youth on youth abusive sexual contact through the clothing. He reported that at the time the allegation was made, the residents were already separated. He immediately alerted his supervisor. Because there was no forensic evidence available, the first responder did not ask that the victim take any actions that could destroy physical evidence as it was not required.

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.

115.365(a)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-903, Section III (F), Pgs. 6-7; and 4-DS-11, Section III (F), Pg. 6. Document: First Responder Duties Residential Services Assess - Respond - Stabilize.

INTERVIEWS:
Division Director of Residential Services

FINDINGS
Agency Policies AS-903, Section III (F), Pgs. 6-7; and 4-DS-11, Section III (F), Pg. 6, address this provision. A review of the document titled, "First Responder Duties Residential Services Assess - Respond - Stabilize," outlines in detail the steps staff are to follow when responding to an allegation. This included the response by security/supervisory/management staff, medical, law enforcement, and SafePlace. The document clearly outlines the institutional plan to coordinate actions taken in response to an incident. Staff interviewed reiterated the protocols outlined in the agency's institutional plan.

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.

115.366(a)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-902, Section III (I), Pgs. 7. The agency reported this is not applicable to the agency. The State of Texas is an at-will employment state.

INTERVIEWS:
Chief Juvenile Probation Officer.

FINDINGS
Agency Policy AS-902, Section III (I), Pgs. 7 addresses this provision. Staff reported this is not applicable to the agency and that the State of Texas is an at-will employment state.

115.366(b)
POLICY AND DOCUMENT REVIEW:
The agency is not required to respond to this provision.

FINDINGS.
This provision is not applicable as the agency is not required to respond to this provision.

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.

115.367(a)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-217, Section III (H), Pg. 3-4; AS-902, Section III (J) (5), Pg. 8; AS-903, Section III (F) (2) (b), Pg. 7, and (G) (1) (f), Pg. 9; AS-904, Section III (G), Pgs. 5-6; and AS-217, Section III (H), Pg. 3. The agency reported there had been one allegation of youth on youth abusive sexual contact within the facility in the past 12 months. The incident involved youth on youth abusive sexual contact through the clothing.

FINDINGS
Agency Policies AS-217, Section III (H), Pg. 3-4; AS-902, Section III (J) (5), Pg. 8; AS-903, Section III (F) (2) (b), Pg. 7, and (G) (1) (f), Pg. 9; AS-904, Section III (G), Pgs. 5-6; and AS-217, Section III (H), Pg. 3 address this provision. Policy requires the Chief, or designee, monitor for any retaliation.

115.367(b)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-217, Section III (H), Pg. 3-4; and AS-904, Section III (G), Pgs. 5-6. The agency reported there had been one allegation of youth on youth abusive sexual contact within the facility in the past 12 months. The incident involved youth on youth abusive sexual contact through the clothing.

INTERVIEWS:
Chief Juvenile Probation Officer, Division Director of Residential Services and Designated Staff Member Charged with Monitoring Retaliation - PREA Coordinator. Resident who Reported a Sexual Abuse.

FINDINGS
Agency Policies AS-217, Section III (H), Pg. 3-4; and AS-904, Section III (G), Pgs. 5-6, address this provision. Staff reported when an investigation is initiated, the individual making the report is told what the expected process will be and if anyone threatens or otherwise makes them feel uncomfortable, they are provided with the name of the person to notify. Staff and residents are informed that any retaliation will be taken seriously and acted upon. Staff reported the process followed and strategies used when monitoring for potential retaliation against both residents and staff. Staff advised SafePlace is offered as a resource for emotional support. The Division Director reported there is a zero tolerance for retaliation. It is expected that information involving any resident is treated in a confidential manner, assigned staff will check in with alleged victims and inquire if there are any issues. Staff will be asked to monitor the situation and report any concerns. The Division Director is charged with monitoring for retaliation, but has the option to delegate the responsibility to another individual. In this case, the alleged abuser was removed the same day that the abusive sexual contact was reported, but was subsequently returned based on court action. Staff immediately initiated extensive monitoring protocols and implemented protective measures for the victim. This required the involvement of key staff and the effort of a multi-disciplinary team. The auditor spoke extensively with the victim who acknowledged he felts safe and reported staff have been very responsive. Because of the agency's mission and the program's treatment goals, the auditor encouraged the facility staff to continue working with the courts and develop effective strategies under these circumstances. The auditor acknowledged the facility developed and implemented effective monitoring protocols and strategies to ensure the continued sexual safety of the victim.

115.367(c)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-217, Section III (H), Pg. 3-4; and AS-904, Section III (G), Pgs. 5-6. The agency reported there had been one allegation of youth on youth abusive sexual contact within the facility in the past 12 months. The incident involved youth on youth abusive sexual contact through the clothing.

INTERVIEWS:
Division Director of Residential Services and Designated Staff Member Charged with Monitoring Retaliation - PREA Coordinator.

FINDINGS
Agency Policies AS-217, Section III (H), Pg. 3-4; and AS-904, Section III (G), Pgs. 5-6, address this provision. Staff reported in detail what they look for when monitoring for retaliation for both residents and staff, and the duration of the monitoring, which meet the standard requirements. The Division Director reported on the strategies that would be employed immediately to protect the alleged victim.

115.367(d)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-904, Section III (G), Pgs. 5-6. The agency reported there had been one allegation of youth on youth abusive sexual contact within the facility in the past 12 months. The incident involved youth on youth abusive sexual contact through the clothing.

INTERVIEWS:
Division Director of Residential Services, and Designated Staff Member Charged with Monitoring Retaliation - PREA Coordinator.

FINDINGS
Agency Policy AS-904, Section III (G), Pgs. 5-6, addresses this provision. In the allegation involving youth on youth abusive sexual contact through the clothing, the Division Director of Residential Services is tasked, per policy, with monitoring for possible retaliation. The Division Director also has the option to delegate the responsibility to another individual. Staff interviewed discussed in detail the type of periodic status checks they conduct when monitoring for retaliation against residents.

115.367(e)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-904, Section III (G), Pgs. 5-6.

INTERVIEWS:
Chief Juvenile Probation Officer and Division Director of Residential Services.

FINDINGS
Agency Policy AS-904, Section III (G), Pgs. 5-6, addresses this provision. Staff interviewed reported any type of retaliation is treated seriously and any allegations made would be reviewed and investigated. If an allegation were to be found true, the appropriate necessary actions would be taken.

115.367(f)
POLICY AND DOCUMENT REVIEW:
The agency is not required to respond to this provision.

FINDINGS
This provision is not applicable as the agency is not required to respond to this provision.

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.

115.368(a)
POLICY AND DOCUMENT REVIEW:
Agency Policy RS-5.100, Sections III (H), Pg. 15, and III(I)(9), Pg. 10. The agency reported there had been no residents who alleged to have suffered sexual abuse who were placed in isolation in the past 12 months.

INTERVIEWS:
Division Director of Residential Services, Staff who Supervise Residents in Isolation, and Medical and Mental Health Staff. At the time of the onsite audit, there were no residents in isolation (for risk of sexual victimization/who alleged to have suffered sexual abuse), therefore no resident was interviewed specific to this provision.

ONSITE REVIEW (TOUR OBSERVATIONS):
During the tour, there was no indication that isolation is used on a regular basis.

FINDINGS
Agency Policy RS-5.100, Sections III (H), Pg. 15, and III(I)(9), Pg. 10, partially addresses this provision. The Division Director reported protective isolation is not used and efforts would continue to find alternatives to isolation. Staff reported the isolation of any resident has not occurred in a long time. Staff confirmed medical and mental health staff would conduct daily visits for any resident in isolation. Agency policy requires the Director to conduct a review of the resident's continued isolation if the isolation exceeds 24 hours and every subsequent 24 hours thereafter. This exceeds the standard, which calls for a review every 30 days. Since there had been no reported isolation, there was no case documentation to review specific to this provision.

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.

115.371(a)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-217 and AS-217B. The agency reported from August 20, 2012 to date, there have been two allegations of youth on youth abusive sexual contact - one in calendar year 2014 and one in 2015. Both cases was referred to law enforcement. According to law enforcement, the 2014 case was suspended because the alleged abuser was deported. The incident in 2015 resulted in a Class C citation that was subsequently transferred to juvenile court.

INTERVIEWS:
Investigative Staff

FINDINGS
Agency Policies AS-217 and AS-217B address this provision. A review of both investigative files reflected both investigations were conducted promptly, thoroughly and objectively. Agency Policy AS-217B, Section (D) states, "Unless otherwise allowed by the Chief or designee, efforts will be made to complete all investigations within five (5) business days." Staff interviewed reported investigations are initiated immediately and that third-party and anonymous reports are also considered, documented and the information included in the final report.

115.371(b)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-217B, Section III (B), Pg. 2. Investigative staff training records.

INTERVIEWS:
Investigative Staff

FINDINGS
Although not required, Agency Policy AS-217B, Section III (B), Pg. 2 addresses this provision. A review of the investigative staff training records, including the investigator assigned to the 2014 and 2015 cases, indicated all investigative staff are trained in the required specialized investigative staff training. Staff interviewed reported receiving the required training.

115.371(c)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-217B. Investigative staff training records.

INTERVIEWS:
Investigative Staff

FINDINGS
Agency Policy AS-217B addresses this provision. A review of the investigative files reflected the required supporting documentation was maintained in the files. Staff interviewed reported in detail the steps followed and information collected and documented during the course of the investigation and retained in the files in accordance with the standard.

115.371(d)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-217B, Section III (E) (2) (a), Pg. 4.

INTERVIEWS:
Investigative Staff

FINDINGS
Agency Policy AS-217B, Section III (E) (2) (a), Pg. 4 addresses this provision. Staff interviewed reported investigations are not terminated solely because the victim recants the allegation and would move forward with the investigation.

115.371(e)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-217B Section III (J) (2) (a). Investigative files.

INTERVIEWS:
Investigative Staff

FINDINGS
Agency Policy AS-217B Section III (J) (2) (a) addresses this provision. A review of the investigative files reflected law enforcement becomes involved when there is a potential for criminal charges being filed. Staff interviewed reported law enforcement becomes involved when there is an indication the case is prosecutable. Staff reported law enforcement would then refer the case for prosecutorial review.

115.371(f)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-217B, Section III (E) (1), Pg. 4, and (F) (1), Pg. 5.

INTERVIEWS:
Investigative Staff. Resident who Reported a Sexual Abuse.

FINDINGS
Agency Policy AS-217B, Section III (E) (1), Pg. 4, and (F) (1), Pg. 5. Staff interviewed reported all information would be considered, documented and assessed as part of the investigation. Staff also reported a polygraph is not a part of the investigative process. The resident interviewed reported the agency did not require him to take a polygraph test about the incident.

115.371(g)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-217B, Section III (H) (4), Pg. 6. Investigative files.

INTERVIEWS:
Investigative Staff.

FINDINGS
Agency Policy AS-217B, Section III (H) (4), Pg. 6 addresses this provision. Staff interviewed reported everything is considered as part of the investigation including whether staff actions or failures to act contributed to the abuse. A review of the investigative files indicated the investigations were thorough. The incident review process, which addresses this provision, was completed.

115.371(h)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-901, Section III (C) (1), Pg. 5.

INTERVIEWS:
Investigative Staff

FINDINGS
Although not required, Agency Policy AS-901, Section III (C) (1), Pg. 5 addresses this provision. The Travis County Sheriff's Office, Austin Police Department, and the Austin Independent School District Police Department are the agencies that have jurisdiction and would conduct criminal investigations. The agency only conducts administrative investigations. There were no criminal investigation files to review in response to this provision as no prosecution referral was warranted. The agency reported from August 20, 2012 to date, there have been two allegations of youth on youth abusive sexual contact - one in calendar year 2014 and one in 2015. Both cases was referred to law enforcement. According to law enforcement, the 2014 case was suspended because the alleged abuser was deported. The incident in 2015 resulted in a Class C citation that was subsequently transferred to juvenile court. Staff interviewed reported law enforcement would have to write reports.

115.371(i)
POLICY AND DOCUMENT REVIEW:
Policy review is not required specific to this provision. One criminal investigation files.

INTERVIEWS:
Investigative Staff

FINDINGS
The agency reported from August 20, 2012 to date, there have been two allegations of youth on youth abusive sexual contact - one in calendar year 2014 and one in 2015. Both cases was referred to law enforcement. According to law enforcement, the 2014 case was suspended because the alleged abuser was deported. The incident in 2015, which was investigated by the Travis County Sheriff's Office, resulted in a Class C citation that was subsequently transferred to juvenile court. Staff interviewed reported if a case is leaning towards a criminal offense, it is referred to law enforcement.

115.371(j)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-217, Section III, (I) Pg. 4. The agency reported from August 20, 2012 to date, there have been two allegations of youth on youth abusive sexual contact - one in calendar year 2014 and one in 2015.

FINDINGS
Agency Policy AS-217, Section III, (I) Pg. 4, address this provision and requires investigation reports will be kept in perpetuity. The auditor reviewed both investigative files.

115.371(k)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-217B, Section III (E) (2) (b-c), Pg. 4.

INTERVIEWS:
Investigative Staff

FINDINGS
Staff interviewed reported an investigation would continue regardless of whether the alleged abuser or alleged victim left the facility.

115.371(l)
POLICY AND DOCUMENT REVIEW:
The agency is not required to respond to this provision.

FINDINGS
This provision is not applicable as the agency is not required to respond to this provision.

115.371(m)
POLICY AND DOCUMENT REVIEW:
AS-904 Section III (B) (4), Pg. 2, and AS-217B Section III (J), Pg. 7.

INTERVIEWS:
Division Director of Residential Services, PREA Coordinator, PREA Compliance Manager, and Investigative Staff

FINDINGS
Although not required, Agency Policies AS-904 Section III (B) (4), Pg. 2, and AS-217B Section III (J), Pg. 7 addresses this provision. Staff interviewed reported the agency's General Counsel oversees this and will cooperate with outside investigative agencies and stay informed on the status of their investigation. Staff reported they would cooperate and hand over evidence to the appropriate outside investigative agency. The Division Director reported he is kept apprised of the status of the investigations.

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.

115.372(a)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-217, Section II(A), Pg. 1; and AS-217B, Section I, Pg. 1. Investigative files.

INTERVIEWS:
Investigative Staff.

FINDINGS
Agency Policies AS-217, Section II(A), Pg. 1; and AS-217B, Section I, Pg. 1, address this provision. A review of the investigative files indicated the proper standard was used in determining that the allegations were founded/substantiated. Staff reported the standard of evidence used to substantiate allegations is the preponderance of the evidence.

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.

115.373(a)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-904, Section III (F) (1) (A), Pg. 4. The agency reported from August 20, 2012 to date, there have been two allegations of youth on youth abusive sexual contact - one in calendar year 2014 and one in 2015. In the 2014 case, the resident departed from the facility before the conclusion of the investigation and law enforcement suspended the case because the alleged abuser was deported. In the 2015 case, the agency reported a criminal/administrative investigation of alleged sexual abuse was completed in the past 12 months and one resident was notified of the results of the investigation.

INTERVIEWS:
Division Director of Residential Services and Investigative Staff.

FINDINGS
Agency Policy AS-904, Section III (F) (1-2), Pgs. 4-5, addresses this provision and requires notification for both sexual abuse and sexual harassment investigations. A review of both investigative files reflected in the 2014 case the resident departed from the facility before the conclusion of the investigation and law enforcement suspended the case because the alleged abuser was deported; in the 2015, the victim wanted to press charges, which resulted in a Class C citation that was subsequently transferred to juvenile court, which returned the resident to the facility. In both cases, the disposition was founded/substantiated. A review of both investigative files reflected in the 2014 case, the resident departed the facility prior to the conclusion of the investigation; in the 2015 case, the resident was provided the notification, as well as the resident's parent/legal guardian. Staff interviewed reported the General Counsel prepares the document regarding the finding of the internal investigation and the resident would be notified, as well as the resident's parent/legal guardian. Per policy, the parent/legal guardian would be notified if the resident is under 18 years of age. The agency policy requirements to notify the resident on the outcome of sexual harassment investigations and also informing parents/legal guardians exceed the standard requirements.

115.373(b)
POLICY AND DOCUMENT REVIEW:
The agency reported a criminal investigation of alleged sexual abuse was completed by an outside agency in the past 12 months and one resident was notified verbally of the results of the investigation by the outside investigative agency.

FINDINGS:
A review of both investigative files reflected in the 2014 case, the resident departed the facility prior to the conclusion of the investigation; in the 2015 case, the resident was provided the notification, as well as the resident's parent/legal guardian. The notification was documented.

115.373(c)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-904, Section III (F) (1) (c) (1-4), Pg. 4. Staff reported there had been no substantiated or unsubstantiated complaint of sexual abuse committed by a staff member, contractor, intern, or volunteer against a resident in the past 12 months.

INTERVIEWS:
Resident who Reported a Sexual Abuse.

FINDINGS
Agency Policy AS-904, Section III (F) (1) (c) (1-4), Pg. 4, addresses this provision. Since there have been no investigations involving staff, contractors, interns or volunteers, there was no documentation to review specific to this provision. The resident interviewed reported the incident involved another resident.

115.373(d)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-904, Section III (F) (1) (d), Pgs. 4-5. Investigative Files

INTERVIEWS:
Resident who Reported a Sexual Abuse.

FINDINGS
Agency Policy AS-904, Section III (F) (1) (d), Pgs. 4-5, addresses this provision. A review of both investigative files reflected in the 2014 case, the resident departed the facility prior to the conclusion of the investigation; in the 2015 case, the resident was provided the notification, as well as the resident's parent/legal guardian. The resident interviewed reported receiving the notification and that his parents were also notified.

115.373(e)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-904, Section III (F) (4), Pg. 5. Investigative files.

FINDINGS
Agency Policy AS-904, Section III (F) (4), Pg. 5, addresses this provision. A review of both investigative files reflected in the 2014 case, the resident departed the facility prior to the conclusion of the investigation; in the 2015 case, the resident was provided the notification and the notification was documented.

115.373(e)
POLICY AND DOCUMENT REVIEW:
The agency is not required to respond to this provision.

FINDINGS
This provision is not applicable as the agency is not required to respond to this provision

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.

115.376(a)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-902, Section III (K), Pg. 8, and AS-904, Section III (D), Pg. 3.

FINDINGS
Although not required, Agency Policies AS-902, Section III (K), Pg. 8, and AS-904, Section III (D), Pg. 3 address this provision

115.376(b)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-904, Section III (D) (1) (a), Pg. 3. The agency reported there have been no staff that have violated agency sexual abuse or sexual harassment policies in the past 12 months.

FINDINGS
Agency Policy AS-904, Section III (D) (1) (a), Pg. 3, addresses this provision. Since there have been no staff investigated, therefore not disciplined for violating agency sexual abuse or sexual harassment policies in the past 12 months, there was no documentation to review specific to this provision.

115.376(c)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-904, Section III (D) (1) (b), Pg. 3. The agency reported there have been no staff that have been disciplined for violation of agency sexual abuse or sexual harassment policies in the past 12 months.

FINDINGS
Agency Policy AS-904, Section III (D) (1) (b), Pg. 3, addresses this provision. Since there have been no staff investigated for violating agency sexual abuse or sexual harassment policies, therefore not disciplined in the past 12 months, there was no documentation to review specific to this provision.

115.376(d)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-904, Section I, Pg. 1, and Section III (D) (2), Pg. 3 and (F) (1) (a), and (F) (3). The agency reported there have been no staff that have been disciplined for violation of agency sexual abuse or sexual harassment policies in the past 12 months.

FINDINGS
Agency Policy AS-904, Section I, Pg. 1, and Section III (D) (2), Pg. 3 and (F) (1) (a), and (F) (3), addresses this provision. Since there have been no staff investigated for violating agency sexual abuse or sexual harassment policies, therefore not terminated in the past 12 months, there was no documentation

to review specific to this provision.

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.

115.377(a)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-901, Section III (C) (1), Pg. 5, and AS-904 Section III (D) (2), and (G) (5). The agency reported there had been no contractor or volunteer reported to law enforcement agencies and relevant licensing bodies for engaging in sexual abuse of residents in the past 12 months.

FINDINGS
Although not required, Agency Policies AS-901, Section III (C) (1), Pg. 5, and AS-904 Section III (D) (2), and (G) (5), address this provision. The agency reported there had been no contractor or volunteer reported to law enforcement agencies and relevant licensing bodies for engaging in sexual abuse of residents in the past 12 months, therefore there was no documentation to review specific to this provision.

15.377(b)
POLICY AND DOCUMENT REVIEW:
Although not required, Agency Policy AS-904, Section III (D) (4), Pg. 3.

INTERVIEWS:
Division Director of Detention Services

FINDINGS
Although not required, Agency Policy AS-904, Section III (D) (4), Pg. 3, addresses this provision. The agency reported there had been no contractor or volunteer reported for engaging in sexual abuse of residents in the past 12 months, therefore there was no documentation to review specific to this provision. Staff interviewed reported any allegations of sexual abuse of residents by contractors or volunteers would be treated the same as if they were regular staff. Human resources would be notified, who would then contact the contractor's point of contact and cease the contract with the contractor. Both volunteers and contractors would be prohibited from having further contact with residents. The Chief Juvenile Probation Officer and Assistant Chief Juvenile Probation Officer would also be notified.

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.

115.378(a)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-904, Section III (E), Pgs. 3-4; RS-5.100, Section III (F), Pgs. 9-13; and RS-6.105, Sections I, Pg. 1, and III(B)(1), Pg. 2. Resident

Orientation Packet. Resident Handbook. The agency reported there was one administrative/criminal investigation finding of youth on youth abusive sexual contact, and that the alleged abuser did not receive disciplinary action as a direct result of the abusive sexual contact. He was placed on disciplinary seclusion based on a separate incident that happened the day after the contact. As a result of the criminal investigation, the alledged abuser was given a Class C citation that was subsequently transferred to Juvenile Court.

FINDINGS
Agency Policies AS-904, Section III (E), Pgs. 3-4; RS-5.100, Section III (F), Pgs. 9-13; and RS-6.105, Sections I, Pg. 1, and III(B)(1), Pg. 2, address this provision. The Resident Orientation Packet, Pgs. 7-8, and Resident Handbook, Pgs.11-17, provide information related to the Code of Conduct and Progressive Disciplinary Sanctions, including sanctions pertaining to sexual abuse and sexual harassment.

115.378(b)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-904, Section III (E), Pgs. 3-4; and RS-5.100, Section III (F) (4), Pgs. 11-13. The agency reported there was one administrative /criminal investigation finding of youth on youth abusive sexual contact, and that the alleged abuser did not receive disciplinary action as a direct result of the abusive sexual contact. He was placed on disciplinary seclusion based on a separate incident that happened the day after the contact. The agency reported there have been no residents placed in isolation for resident-on-resident sexual abuse as a disciplinary sanction in the past 12 months.

IINTERVIEWS:
Division Director of Residential Services

FINDINGS
Agency Policies AS-904, Section III (E), Pgs. 3-4; and RS-5.100, Section III (F) (4), Pgs. 11-13, address this provision. Staff interviewed reported a resident on resident sexual abuse incident would be referred to the court system for possible criminal sanctions; additionally, such behavior would be considered a major rule violation. The treatment team would identify additional goals or intervention the resident may need to work on. Staff reported isolation is used as a disciplinary sanction.

115.378(c)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-904, Section III (E) (2), Pg. 3; and AS-905, Section III (D) (3), Pg. 4.

INTERVIEWS:
Division Director of Residential Services

FINDINGS
Agency Policies AS-904, Section III (E) (2), Pg. 3; and AS-905, Section III (D) (3), Pg. 4, address this provision. Staff reported the resident's mental disability or mental illness would be considered when determining sanctions

115.378(d)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-904, Section III (E) (5), Pg. 3, and (E) (6) (a-b); and RS-5.100, Section III(E)(2), Pgs. 7-8.

INTERVIEWS:
Medical and Mental Health Staff

FINDINGS
Agency Policies AS-904, Section III (E) (5), Pg. 3, and (E) (6) (a-b); and RS-5.100, Section III(E)(2), Pgs. 7-8, address this provision. Staff interviewed reported the offending resident is offered therapy, counseling, or other intervention services, but would not require the resident's participation as a condition of access to any rewards-based behavior management system or programming or education.

115.378(e)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-904, Section III (E) (4), Pg. 3; and RS-5.100, Section III(F), Pg. 8, address this provision. The agency reported there were no reported incidents involving sexual contact of residents with staff.

FINDINGS
Agency Policies AS-904, Section III(E)(4), Pg. 3; and 10-DS-2, Section III(E), Pg. 7, address this provision. The agency reported there were no reported incidents involving sexual contact of residents with staff, therefore there was no documentation to review specific to this provision.

115.378(f)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-904, Section III (C), Pg. 2.

FINDINGS
Agency Policy AS-904, Section III(C), Pg. 2, addresses this provision.

115.378(g)
POLICY AND DOCUMENT REVIEW:

Agency Policies AS-901, Section I, Pg. 1; AS-902, Section I, Pg. 1, and AS-904, Section III (E) (1).

FINDINGS
Agency Policies AS-901, Section I, Pg. 1; AS-902, Section I, Pg. 1, and AS-904, Section III (E) (1), address this provision.

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.

Agency Policies AS-905, Section III (A) (1), Pg. 1; and 8-DS-5, Section III (C), Pg. 2, address this provision. The agency reported 100% of the residents that disclosed prior victimization during screening were offered a follow up meeting with medical or a mental health practioner. Forms: Health Assessment Screening, Travis County Juvenile Probation Department Care Plan, Medication Administration Record, Physician's Progress and Health Care Notes, Sick Call, Counselor Daily Contact Log, and Counselor Referral Form. Random selection of resident files.

INTERVIEWS:
Residents who Disclosed Sexual Victimization at Risk Screening. Staff Responsible for Risk Screening.

FINDINGS
Agency Policies AS-905, Section III (A) (1), Pg. 1; and 8-DS-5, Section III (C), Pg. 2, address this provision. A review of the forms used by the department demonstrate how the intake screening staff, medical and mental health staff document the follow-up services residents with prior sexual victimization disclose during the screening process. Staff interviewed reported they work with the counselors by notifying them immediately and doing a referral. Residents interviewed reported being referred to medical and mental health staff for follow-up. A review of the resident files reflected the residents did receive a follow-up meeting with medical and mental health practitioners as required.

115.381(b)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-905, Section III (A) (1-2), Pgs. 1-2. The agency reported 100% of the residents who have previously perpetrated sexual abuse were offered a follow up meeting with a mental health practitioner. Randomly selected resident file.

INTERVIEWS:
Staff Responsible for Risk Screening.

FINDINGS
Agency Policy AS-905, Section III (A) (1-2), Pgs. 1-2, addresses this provision. Staff interviewed reported residents are referred to mental health staff for follow-up. A review of a randomly selected resident file reflected the resident did receive a follow-up meeting with a mental health practitioner as required.

115.381(c)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-902, Section III (F) (1), Pg. 5, and AS-905, Section III (A) (5), Pg. 2.

ONSITE REVIEW (TOUR OBSERVATIONS):
During the onsite tour, the auditor noted medical and mental health staff have designated space where staff can privately meet with residents. Medical and Mental Health records are maintained separately and shared according to policy.

FINDINGS
Agency Policies AS-902, Section III (F) (1), Pg. 5, and AS-905, Section III (A) (5), Pg. 2, address this provision.

115.381(d)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-905, Section III (A) (6), Pg. 2. Form: Consent for Disclosure of ANE (Abuse, Neglect and Exploitation).

INTERVIEWS:

Medical and Mental Health Staff

FINDINGS
Agency Policy AS-905, Section III (A) (6), Pg. 2, addresses this provision. Staff interviewed reported they use the consent form for residents over 18 years of age.

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.

115.382(a)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-905, Section I, Pg. 1, and Section III (A) (2), and (B) (1), Pg. 2; and 8-DS-5, Section III (G and H), Pg. 4.

INTERVIEWS:
Medical and Mental Health Staff. Resident who Reported a Sexual Abuse.

FINDINGS
Although not required, Agency Policies AS-905, Section I, Pg. 1, and Section III (A) (2), and (B) (1), Pg. 2; and 8-DS-5, Section III (G and H), Pg. 4, address this provision. Staff interviewed reported residents would be provided emergency medical treatment immediately and that the nature and scope of the services are determined according to their professional judgement. The resident interviewed reported being seen by the unit counselors and the therapist.

115.382(b)
POLICY AND DOCUMENT REVIEW:
Agency Policy 8-DS-5, Section III (G) (1), Pg. 4. Form: Counselor Referral Form.

INTERVIEWS:
Security Staff and Non-Security Staff First Responders.

FINDINGS
Although not required, Agency Policy 8-DS-5, Section III (G) (1), Pg. 4, require staff notify nursing staff if they believe a juvenile is actively experiencing a mental health crisis. The agency uses the Counselor Referral Form in response to this provision. Staff who responded to the 2015 incident were interviewed and reported notifying the supervisor. According to the resident interviewed, a unit counselor responded to the incident within an hour.

115.382(c)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-905, Section III, (B) (3) (c-d), Pg. 3.

INTERVIEWS:
Medical and Mental Health Staff. Resident who Reported a Sexual Abuse.

FINDINGS
Although not required, Agency Policy AS-905, Section III, (B) (3) (c-d), Pg. 3, addresses this provision. Staff interviewed reported the required information and services would be provided immediately. The 2015 youth on youth sexual abuse incident involved contact over clothing.

115.382(d)
POLICY AND DOCUMENT REVIEW:
AS-905, Section III, (B) (2), Pg. 2, and (C) (3), Pg. 3; and 8-DS-5.

FINDINGS
Although not Required, Agency Policies AS-905, Section III, (B) (2), Pg. 2, and (C) (3), Pg. 3; and 8-DS-5 address this provision.

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.

115.383(a)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-905, Section III (B and C), Pgs. 2-3.

ONSITE REVIEW (TOUR OBSERVATIONS):
During the tour, the auditor observed the medical section at the facility. Medical services are available 24/7 at the facility. Mental health counselors provide treatment and counseling to residents.

FINDINGS
Although not required, Agency Policy AS-905, Section III (B and C), Pgs. 2-3, addresses this provision.

115.383(b)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-905, Section III (B) (4) and (C) (4), Pg. 3.

INTERVIEWS:
Medical and Mental Health Staff. Resident who Reported a Sexual Abuse.

FINDINGS
Although not required, Agency Policy AS-905, Section III (B) (4) and (C) (4), Pg. 3, addresses this provision. Staff interviewed reported follow-up services would be matched with appropriate intervention services. The resident interviewed reported having access to the unit counselors and therapist.

115.383(c)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-905, Section III (A) (4), Pg. 2.

INTERVIEWS:
Medical and Mental Health Staff.

FINDINGS
Although not required, Agency Policy AS-905, Section III (A) (4), Pg. 2, addresses this provision. Staff interviewed reported the services provided go beyond the community level of care.

115.383(d)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-905, Section III (B) (3) (d), Pg. 3.

INTERVIEWS:
At the time of the onsite audit, there were no female residents who reported a sexual abuse at the facility, therefore no female resident was interviewed specific to this provision.

FINDINGS
Although not required, Agency Policy AS-905, Section III (B) (3) (d), Pg. 3, addresses this provision.

115.383(e)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-905, Section III (B) (3) (d), Pg. 3.

INTERVIEWS:

Medical and Mental Health Staff. At the time of the onsite audit, there were no female residents who reported a sexual abuse at the facility, therefore no female resident was interviewed specific to this provision.

FINDINGS
Although not required, Agency Policy AS-905, Section III (B) (3) (d), Pg. 3, addresses this provision. Staff interviewed reported the required information and services would be provided.

115.383(f)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-905, Section III (B) (3) (c), Pg. 3. The agency reported there were no allegations of resident sexual abuse requiring medical services.

INTERVIEWS:
At the time of the onsite audit, there were no female residents who reported a sexual abuse at the facility, therefore no female resident was interviewed specific to this provision.

FINDINGS
Although not required, Agency Policy AS-905, Section III (B) (3) (c), Pg. 3, addresses this provision.

115.383(g)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-905, Section III (B) (2), Pg. 2, and (C) (3), Pg. 3, addresses this provision.

INTERVIEWS:
Resident who Reported a Sexual Abuse.

FINDINGS
Although not required, Agency Policy AS-905, Section III (B) (3) (d), Pg. 3, addresses this provision. At the time of the audit, the resident reported he was provided access to treatment services and did not report having to pay for any treatment.

115.383(h)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-905, Section III (D) (1), Pg. 3.

INTERVIEWS:
Medical and Mental Health Staff.

FINDINGS
Although not required, Agency Policy AS-905, Section III (D) (1), Pg. 3, addresses this provision. Staff interviewed reported the resident would be referred, and the treatment provider would respond immediately.

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.

115.386(a)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-906, Section II (A), Pg. 1. The agency reported there was one administrative/criminal investigation of alleged sexual abuse completed within the past 12 months. Investigative file.

FINDINGS
Although not required, Agency Policy AS-906, Section II (A), Pg. 1, addresses this provision. A review of the investigative file reflected the department had completed a sexual abuse incident review at the conclusion of the investigation.

115.386(b)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-906, Section II (A) (1), Pg. 1. The agency reported there was one administrative/criminal investigation of alleged sexual abuse followed by a sexual abuse incident review within 30 days within the past 12 months. Investigative file.

FINDINGS
Although not required, Agency Policy AS-906, Section II (A) (1), Pg. 1, addresses this provision. A review of the investigative file reflected the department had completed a sexual abuse incident review as required.

115.386(c)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-906, Section II (A) (2), Pg. 1.

INTERVIEWS:
Division Director of Residential Services

FINDINGS
Although not required, Agency Policy AS-906, Section II (A) (2), Pg. 1, addresses this provision. Staff interviewed reported the incident review team includes the Chief Juvenile Probation Officer, Assistant Chief Juvenile Probation Officer, General Counsel, Division Director of Detention Services, Division Managers, Supervisory Staff, and staff involved in the incident. A review of the Incident Review Report indicated the PREA Coordinator also participates.

115.386(d)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-906, Section II (A) (4-5), Pgs. 2-3. Incident Review Report

INTERVIEWS:
Division Director of Residential Services, PREA Compliance Manager, Incident Review Team

FINDINGS
Although not required, Agency Policy AS-906, Section II (A) (4-5), Pgs. 2-3, addresses this provision. Staff interviewed referenced all the elements needing to be considered, examined, and assessed. Staff reported it would be helpful to have video resources to assist in the assessment of the incident. The Incident Review Team member provided detailed information of all the elements addressed by the team. Staff interviewed acknowledged a report is completed and includes any recommendations for improvement. Staff reported the Incident Review Report is submitted to the Compliance Unit, which is the unit the PREA Compliance Manager is assigned to, where it is reviewed and actions needed to be taken in response to the report are considered. Policy requires the Chief Juvenile Probation Officer to brief the Juvenile Board on the findings and recommendations of the Sexual Abuse Review Team and the subsequent response to the findings, which substantially exceeds the requirement of this provision.

115.386(e)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-906, Section II (A) (4), Pg. 2-3.

FINDINGS
Although not required, Agency Policy AS-906, Section II (A) (4), Pg. 2-3, addresses this provision.

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.

115.387(a and c)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-906, Section II (B), Pg. 3. Database.

FINDINGS
Although not required, Agency Policy AS-906, Section II (B), Pg. 3, addresses this provision. A review of the database reflected a comprehensive system designed to maintain various elements for the required data for sexual abuse allegations, plus also data for sexual harassment allegations. 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, and all serious incidents as defined by the TJJD, which includes youth sexual conduct.

115.387(b)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-906, Section II (B), Pg. 3.

FINDINGS
Although not required, Agency Policy AS-906, Section II (B), Pg. 3, addresses this provision. A review of the database reflected a comprehensive system designed to maintain various elements for the required data for sexual abuse allegations, plus also data for sexual harassment allegations.

115.387(d)
Agency Policy AS-906, Section II (B), Pg. 3.

FINDINGS
Agency Policy AS-906, Section II (B), Pg. 3, addresses this provision. A review of the database reflected a comprehensive system designed to maintain various elements for the required data for sexual abuse allegations, plus also data for sexual harassment allegations.

115.387(e)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-906, Section II (C), Pg. 3, addresses this provision.

FINDINGS
Agency Policy AS-906, Section II (C), Pg. 3, addresses this provision.

115.387(f)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-906, Section II (B) (3), Pg. 3.

FINDINGS
Although not required, Agency Policy AS-906, Section II (B) (3), Pg. 3, addresses this provision.

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.

115.388(a)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-906, Section II (D) (1), Pg. 3. Annual report, dated March 2016, posted on website.

INTERVIEWS:
Chief Juvenile Probation Officer, PREA Coordinator, and PREA Compliance Manager.

FINDINGS
Although not required, Agency Policy AS-906, Section II (D) (1), Pg. 3, addresses this provision. A review of the annual report reflects all the elements required by this provision. Staff interviewed reported in detail the process followed when reviewing the data, identifying problem areas and corrective action, and preparing the annual report.

115.388(b)
POLICY AND DOCUMENT REVIEW:

Agency Policy AS-906, Section II (D) (2), Pg. 3.

FINDINGS
Although not required, Agency Policy AS-906, Section II (D) (2), Pg. 3, addresses this provision.

115.388(c)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-906, Section II (D) (2) (A), Pg. 3. Annual report.

INTERVIEWS:
Chief Juvenile Probation Officer

FINDINGS
Although not required, Agency Policy AS-906, Section II (D) (2) (A), Pg. 3, addresses this provision. Staff interviewed reported the Annual report is reviewed and approved by her. A review of the posted annual report reflected the signatures of the Chief Juvenile Probation Officer and PREA Coordinator.

115.388(d)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-906, Section II (D) (2) (c), Pg. 4.

INTERVIEWS:
PREA Coordinator

FINDINGS
Although not required, Agency Policy AS-906, Section II (D) (2) (c), Pg. 4, addresses this provision. Staff interviewed reported all personal identifying information and personal health information is redacted. The reports would reflect only basic demographic information.

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.

115.389(a)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-906, Section II (D) (2) (d), Pg. 4.

INTERVIEWS:
PREA Coordinator

FINDINGS
Agency Policy AS-906, Section II (D) (2) (d), Pg. 4, addresses this provision. Staff interviewed reported access to any data is restricted to the Compliance Unit staff and is password protected.

115.389(b)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-906, Section II (D) (2) (a), Pg. 4. Aggregated data on website.

FINDINGS
Although not required, Agency Policy AS-906, Section II (D) (2) (a), Pg. 4, addresses this provision. The data posted on the website includes data from Calendar Years 2014 and 2015.

115.389(c)
POLICY AND DOCUMENT REVIEW:

Agency Policy AS-906, Section II (D) (2) (b), Pg. 4. Aggregated data on website.

FINDINGS
Although not required, Agency Policy AS-906, Section II (D) (2) (b), Pg. 4, addresses this provision. The data posted on the website includes data from Calendar Years 2014 and 2015.

115.389(d)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-906, Section II (D) (2) (e), Pg. 4. Aggregated data on website.

FINDINGS
Although not required, Agency Policy AS-906, Section II (D) (2) (e), Pg. 4, addresses this provision. The data posted on the website includes data from Calendar Years 2014 and 2015.

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.

Ana T. Aguirre, ATA3 Consulting, LLC (Electronic Signature) 01-18-17

Auditor Signature Date