PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: July 2, 2017

Auditor Information			
Auditor name: Ana T. Aguirre, ATA3 Consulting, LLC			
Address: PO Box 19748, Austin, TX 78760			
Email: ata3consulting@gmail.com			
Telephone number: 512-708-0647			
Date of facility visit: May 10-12, 2017			
Facility Information			
Facility name: Gardner-Betts Juvenile Justice Center			
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: Danica Castaneda			
Number of staff assigned to the facility in the last 12 months: 83; 21 no longer employed at facility			
Designed facility capacity: 120			
Current population of facility: 39			
Facility security levels/inmate custody levels: Maximum			
Age range of the population: 10-18			
Name of PREA Compliance Manager: Steve Owen		Title: Accreditation and Compliance Officer	
Email address: stephen.owen@traviscountytx.gov		Telephone number: 512-854-7055	
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: Residential Services Division Manager and PREA Coordinator	
Email address: brandy.baptiste@traviscountytx.gov		Telephone number: 512-854-5675	

NARRATIVE

The Prison Rape Elimination Act (PREA) onsite audit of the Gardner-Betts Juvenile Justice Center Pre-Adjudication Facility in Austin, Texas, was conducted on May 10-12, 2017, by Ana T. Aguirre, ATA3 Consulting, LLC. The last facility onsite PREA audit was conducted May 2-16, 2016. 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. Ms. Aguirre toured the pre-adjudication facility program and operational areas, including a few common areas shared with the post-adjudication facility, which were minimal. The auditor noted, because of the type of services provided, any allegation of sexual abuse or sexual harassment will be reported to at least one of the following state agencies: Texas Juvenile Justice Department (TJJD), Department of Family Protective Services (DFPS), and the Department of State Health Services (DSHS).

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 the 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 29, 2017, 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: Court Services Entrance, Detention Hearing Waiting Area, Exit for Intake to Public Hallway, Intake Medical, Intake Secure Hallway Entrance, Intake Shower Room, Male Holding Room, PDA Door to Intake, PDA Where Kids Wait for Court, Public Corridor to Intake Area, Restitution window, Travis County Sheriff's Office Booking Area, Visitation Parent Entrance, Library, Cafeterias, Gymnasium, and all the Housing Units, including the dually certified pre/post-adjudication housing units. The notices were printed in bright neon colors (pink, green, yellow, and purple) 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; Danica Castaneda, Division Director of Detention Services; Brandy Baptiste, PREA Coordinator; and Steve Owen, PREA Compliance Manager; was held on Wednesday, May 10, 2017. The audit process was explained with the staff. An exit interview was conducted on Friday, May 12, 2017.

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, and volunteers. The auditor formally interviewed 12 residents; and over 33 staff, of which 18 were specialized staff and included contractors and volunteers. The auditor interviewed the Chief Juvenile Probation Officer, Division Director of Detention 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, SAFE/SANE staff, volunteers and contractors, investigative staff, staff that perform screening for risk of victimization and abusiveness, incident review team staff, designated staff member charged with monitoring retaliation, 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 during the first day of the audit, May 10, 2017, from approximately 9:00 to 11:15 AM, 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 (Hotline Number, and Victim Services Information); resident intake, admission, and search procedures; resident programming (educational and vocational classrooms, and library); and areas designated for staff support/operational areas (laundry, maintenance, and warehouse). The auditor noted the 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 the onsite observation of each shift.

The facility operates under the following Agency-wide Administrative Services (AS) Policies under Chapter: Abuse and Neglect Prevention and Response, which include the following: AS-901 Subject: Reporting of Child Abuse, Neglect and Exploitation; AS-902 Subject: Preventing and Detecting Sexual Abuse and Harassment; AS-903 Subject: First Responder Duties; AS-904 Subject: Corrective Action and Notifications; AS-905 Subject: Services for Victims of Sexual Abuse; AS-906 Subject: Incident Reviews and Data Collection; and AS-209 Chapter: Personnel; Subject: Code of Ethics / Staff - Juvenile Relationships; and AS-401 Chapter: Training and Staff Development; Subject: Staff Training and Development Plan.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Gardner-Betts Juvenile Justice Center Pre-Adjudication Facility is located at 2515 South Congress Avenue in Austin, Texas. The facility is under the Detention Services Division and is one division of the Travis County Juvenile Probation Department. The Detention Services Division provides secure, short-term housing and care for pre-adjudicated male and female juveniles between 10 - 18 years of age. The facility reported it contains four buildings. The 120-bed facility has fourteen* housing units with a total of 104 single-cell rooms and eight double occupancy rooms. Each housing unit is equiped with a day room and at least one central restroom/shower. The facility has 10 housing units that have secured, wet rooms. The facility does not have a specified unit used solely for segregation. Two of the housing units are solely designated to house female residents; four are solely designated to house male residents. The remaining units are designated for female or male residents depending on the needs of the population. Four housing units were vacant at the itme of the onsite audit.

*The department dually certified two (eight single-cell rooms in each unit) of the 14 housing units for pre/post-adjudication purposes. At the time of the audit, the two housing units were being operated under the Post-Adjudication Facility program and housing post-adjudication residents. For the purpose of the audit, the auditor did include both housing units as part of the tour due to their close proximity to the pre-adjudication program operations. The auditor did not interview or include in the population count the residents under the care and control of the post-adjudication program operations. The auditor did note the pre and post-adjudication resident populations are kept separate at all times.

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 639 residents, which included 33 male residents and 6 female residents. The agency reported 1,702 residents had been admitted to the facility in the past 12 months, with 623 residents whose length of stay in the facility was for 10 or more day, and 1,068 residents admitted to the facility whose length of stay in the facility was for 72 or more hours. The agency reported 83 employed staff at the facility during the past 12 months and 21 of those individuals are no longer employed. The agency reported 19 contracts with contractors who might have contact with residents and 19 volunteers and contractors currently authorized to enter the facility. The agency reported there are 12 staff trained to conduct administrative investigations.

SUMMARY OF AUDIT FINDINGS

During the past 12 months, the Gardner-Betts Juvenile Justice Center Pre-Adjudication Facility reported there were no allegation of sexual abuse or sexual harassment reported. 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.

Overall, the interviews with staff indicated a high level of expectation that the emotional well-being and physical safety of all residents is of utmost importance. Many staff are tenured, which provides stability in the operations and program implementation. The auditor noted all facility staff, contract staff, and volunteers interviewed would not hesitate reporting any allegation of sexual abuse or sexual harassment, including any other type of abuse, neglect or exploitation. There was a strong indication the agency and facility's leadership, in collaboration with the Compliance Unit, have established strong collaborative efforts in response to ongoing implementation of the PREA standards. Based on staff and resident interviews, there was a strong indication the PREA standards continue to be implemented as required and in accordance with the agencies policies.

Overall, the interviews with 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 residents receive the PREA information verbally, in written format (Orientation Packet, Resident Handbook, PREA Brochures) during intake and orientation, as well as weekly via group sessions every Saturday. All staff, including specialized and contract staff, and volunteers, 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: 9

Number of standards met: 32

Number of standards not met: 0

Number of standards not applicable: 0

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-905, AS-209, and 10-DS-2. Resident Handbook, PREA Posters, and PREA Brochures.

FINDINGS:
Agency Policies AS-901, AS-902, AS-905, AS-209, and 10-DS-2 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 the PREA standards, 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 and Facility's Organizational Charts.

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 in the Residential Services administrative section at the agency. The PREA Compliance Managers have offices in the administrative section of the agency.

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. At the time of the onsite audit, the PREA Coordinator position was vacant and has been vacant since October 17, 2016. The individual who acted as the PREA Coordinator was still employed with the Department and had been promoted to the Division Manager for Residential Services position. The agency reported via memo, dated March 29, 2017, the same individual who served as the PREA Coordinator would retain the duties of that position until the position is filled or the suitability is reevaluated when the position is filled. The Chief Executive Officer indicated that training and expertise in the PREA standards may override the position designation in the organization chart and the duties may remain with the original person fulfilling that role.

Staff reported she is the current Residential Services Manager over the Non-Secure Program and has also retained the duties of the PREA Coordinator. She reported she currently splits her duties between Residential Services and the PREA compliance efforts. The recent expansion of the compliance team has been very helpful. With the addition of a third team member, one assigned to each of the three programs (detention, residential-secure, and residential-non-secure) has been very helpful. She reported the team members are a self-directed work team and she makes herself available as needed. She reported the agency has provided for she and the team to attend the American Correctional Association (ACA), Correctional Accreditation Manager's Association (CAMA) Conferences, and she also attended and completed the PREA Auditor Training.

A review of the agency policy, agency's organization chart, and based on the interview, the designated agency's acting 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 and Facility's Organizational Charts.

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 office space he shares with the other two PREA Compliance Managers

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. Staff reported having enough time to focus on PREA related activities and the addition of a Compliance Manager Position, effective February 2017 (assigned to the post-adjudication non-secure facility) has helped. He reported he is meets with the Facility Administrators (Division Director and Division Manager) on a regular basis to ensure compliance with the PREA standards is maintained. A review of the agency policy, agency's organization chart, and based on the interview of 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. 7. Contracts.

FINDINGS:
Although not required, Agency Policy AS-902, Section III (H), Pg. 7, addresses this provision.
The agency reported there were ten (10) contracts for the confinement of residents that the agency had with private entities or other government agencies that meet the PREA definition of juvenile facilities and require the contracting facility to adopt and comply with the PREA standards. A review of the contracts indicated two of the facilities were not required to have a PREA audit based on the data provided indicating less than 50% of their admissions were juvenile probation clients. A third facility, listed as a post-adjudication facility and a placement option over several years, was found to no longer be in operation. The agency immediately initiated steps to formally cancel the contract. A review of the remaining seven (7) contracts indicated each facility had completed the initial onsite PREA audit process and had a continued contractual obligation to adopt and comply with the PREA standards.

115.312(b)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-902, Section III (H), Pg. 7. Contracts, PREA Audit Reports.

INTERVIEWS:
Contract Administrator

FINDINGS:
Although not required, Agency Policy AS-902, Section III (H), Pg. 7, addresses this provision. Staff reported all contracts automatically renew and there have been no new contracts the agency has entered into in the past 12 months. Staff added she was gathering follow-up information on three of the ten facilities currently under contract specific to PREA. Staff reported if any abuse outcry or allegation were made by a resident placed in a contract facility, they would immediately follow-up with the facility and the compliance team. The officers would staff the case with the manager and review whether the allegation was relevant to PREA. All external reporting (law enforcement and the TJJD) would be done timely, plus the resident's parents would be notified and kept up-to-date on the status. The resident's safety would be paramount. Staff reported there have not been any outcries involving staff at any

of the facilities and if there were any incidents, an Incident Report would be requested of the TJJD and the faciity.

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) (5), Pg. 2, and (D) (3), Pgs. 3-4. Staffing Plans: Pre-adjudication Facility; Post-adjudication Facility.

INTERVIEWS:
Division Director of Detention Services
PREA Compliance Manager

FINDINGS:
Although not required, Agency Policy AS-902, Section III (A) (5), Pg. 2, and (D) (3), Pgs. 3-4, addresses this provision. The agency submitted an Annual Staffing Plan Review Memo dated March 28, 2017, reflecting the annual staffing plan review was conducted on November 15, 2016, for both facilities: Pre-Adjudication and Post-Adjudication Facilities. The agency reported the pre-adjudication facility's average daily number of residents is 57 and that the daily number of residents in which the staffing plan was predicated on is 120.

Staff reported they have an annual meeting to review trends, staffing in all divisions, housing assignments, identify what needs to be modified and ensure incidents do not occur. There are plans in place to get additional cameras throughout the facility with the ability to record. Part of this initiative required a walk-thru to determine the appropriate placement of the new cameras. In the meantime, unannounced rounds are conducted to monitor activity. Staff reported a staffing plan is in place and they follow the TJJD, ACA, DSHS and PREA standards, take into consideration the composition of the resident population and their needs, scheduled programming, and staff placement. Additionally, staff reported other relevant factors considered include the needs of the LGBTQI residents and incidents of substantiated and unsubstantiated sexual abuse. Staff reported efforts to ensure ongiong compliance with the staffing plan include the following: daily printouts of the populations by unit and gender; supervision pass-down reports; daily staff shift assessments; and daily incident reviews and repairs as needed. Staff reported all eyes are on the department, but also within the division. 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 developed a plan of action to secure additional video monitoring technology to enhance the supervision and safety of the residents. 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 was provided and reviewed by the auditor and demonstrated the department's ongoing efforts towards full implementation of this project.

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

INTERVIEWS:
Division Director of Detention Services.

FINDINGS:
Staff reported they have complied with the staffing plan and mandatory overtime plus having part-time staff are utilized to maintain proper staff coverage. 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:
Agency Policy 5-DS-5, Section III (A), Pg. 3. Facility Population Rosters

INTERVIEWS:
Division Director of Detention Services

FINDINGS:
Although not required, Agency Policy 5-DS-5, Section III (A), Pg. 3, addresses staff to resident ratios. Current policy requires the facility comply 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. Staff reported the facility complies with the current TJJD, ACA, and PREA standards and have been working towards meeting the stricter PREA ratios. The PREA 1:8 waking hour and 1:16 sleeping hour staffing ratios for this provision go into effect on October 1, 2017. At the time of the onsite audit, the facility appeared to be ahead of schedule in meeting the requirements of this provision. The auditor requested additional supporting documentation. A review of randomly selected daily resident population rosters between July 2016 and June 2017, indicated for the month of August 2016 and from October 2016 to June 2017, the facility consistently maintained a 1:8 staff to resident ratios. Based on the review of the documentation provided, the auditor determined the facility is in compliance with this provision.

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. The auditor interviewed the PREA Coordinator. She reported she is consulted on the staffing plan, which occur annually. Staff reported the annual review process is about to start. A mid-year review is done on a smaller scope specific to the facility. In preparing for the 1:8 daytime staff ratios, which will need to be in place by October 2017, staff are evaluating resources and where they are. During the onsite audit, a review of the agency policy, staff interview, and the agency's current staffing plan indicate all the required elements are in place. 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 was provided and reviewed by the auditor and 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, Pgs. 4-5. Management Walk-Thru Forms.

INTERVIEWS:
Intermediate and Higher-Level Facility Staff

ONSITE REVIEW (TOUR OBSERVATIONS):
A review of log entries indicated management staff conducts unannounced rounds.

FINDINGS:
Agency Policy AS-902, Section III (E) (4), Pgs. 4-5, addresses this provision. Agency policy defines the management team to include the following positions: facility's Division Director, Division Manager, Casework Manager and Shift Supervisor. Documentation of Detention Services Management Walk Thru's for the dates of November 6-12, 2016, November 13-19, 2016, January 1-7, 2017, and January 22-28, 2017 were requested and provided to the auditor for review. A review of the documented log entries indicated Casework Managers and Shift Supervisors conduct unannounced rounds during day and night shifts. The documentation reviewed during these same time frames also included completed Management Walk-Thru Forms, which are the responsibility of the Division Managers and Accreditation and Compliance Unit and provided additional supporting documentation of unannounced rounds. The completed forms reflected these unannounced rounds were conducted during the day and evening shifts. Two Intermediate and Higher-Level Facility Staff were interviewed by the auditor specific to this provision. Staff reported unannounced rounds are done nightly at least one time. One staff member reported on quiet nights, he may do three to four unannounced rounds and when busy conduct the unannounced round twice on shift. Staff reported these unannounced rounds are documented in the logbook. One staff member indicated other staff members would not know when the unannounced rounds are being conducted since this is a practice that has been in place for a long time. The second staff member noted a strategy he utilizes while conducting unannounced rounds. A review of the agency policy, log entries, completed Management Walk-Thru Forms, and staff interviews, indicate multiple levels of management conducting unannounced rounds on all shifts, 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:
Texas Administrative Code 343.260 (b) (1), Pg. 20, and 343.432 (b-c), Pg. 51. Agency Policy 5-DS-8, Section III (C) (1) (c), Pg. 3 and (C) (3) (c), Pg. 4. Agency Memo.

INTERVIEWS:
PREA Coordinator

FINDINGS:
Texas Administrative Code 343.260 (b) (1), Pg. 20, and 343.432 (b-c), Pg. 51, prohibits cross-gender viewing and searches. Agency Policy 5-DS-8, Section III (C) (1) (c), Pg. 3 and (C) (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 prohibit cross-gender strip searches, cross-gender visual body cavity searches or cross-gender pat searches of residents. Because the state standards do not have provisions for exigent circumstances, the facility does 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, dated March 28, 2017, by the agency to the auditor, and an informal interview with the PREA Coordinator confirmed this practice. A review of the the Texas Administrative Code, 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:
Texas Administrative Code 343.260 (b) (1), Pg. 20, and 343.432 (b-c), Pg. 51. Agency Policy 5-DS-8, Section III (C) (1) (c-d), Pg. 3. Training Records for Cross-Gender and Transgender Pat Searches.

INTERVIEWS:
Random Selection of Staff
Random Selection of Residents

FINDINGS:
Agency Policy 5-DS-8, Section III (C) (1) (c-d), 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 11 randomly selection of staff and 11 randomly selection of residents. All staff reported they are prohibited from conducting cross-gender searches. Some interviewed reported they have been trained to conduct cross-gender pat-down searches in the event of an emergency or exigent circumstance. Staff reported there are 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. Training records were requested and provided to the auditor for review. The training records, dated August 2016, reflected security and medical staff had completed this training. A review of the Texas Administrative Code, agency policy, training records, 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, certain staff are trained to conduct cross-gender pat-down searches in the event of an emergency or exigent circumstance, which the auditor determined the agency demonstrates it substantially exceeds the requirements of this provision.

115.315(c)
POLICY AND DOCUMENT REVIEW:
Agency Policy 5-DS-8, Section III(C) (1) (c-d), Pg. 3 and (C) (3) (b), Pg. 4.

FINDINGS:
Agency Policy 5-DS-8, Section III (C) (1) (c-d), Pg. 3 and (C) (3) (b), Pg. 4, addresses this provision. Agency policy requires strip searches are conducted by staff of the same gender as the juvenile. Agency policy requires female Juvenile Supervision Officers (JSOs) frisk search female juveniles and male JSOs frisk search male juveniles. The agency reported there have been no incidents of cross-gender strip or 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 facility does 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 5-DS-5, Section III (B) (2-3), Pg. 3.

INTERVIEWS:

Random Selection of Staff
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 and 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 5-DS-5, Section III (B) (2-3), Pg. 3, 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. The 11 random staff interviews reflected staff are aware and are required to announce themselves when entering a housing unit with residents of the opposite gender. The 11 random residents reported 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. Two residents stated they observed when the signs were put out alerting staff of the opposite gender not to enter the unit. 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 5-DS-8, Section III (B) (8), Pg. 3.

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

FINDINGS:
Agency Policies AS-1203, Section III (A) (4), Pg. 3, and 5-DS-8, Section III (B) (8), Pg. 3, address this provision. Staff reported they are prohibited from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. 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 Policies AS-1203, Section III (I) (2), Pg. 6, and AS-401, Section III (F) (5) (1), Pg. 11. Agency Memo, dated March 28, 2017. Training Records for Cross-Gender and Transgender Pat Searches.

INTERVIEWS:
Random Sample of Staff

FINDINGS:
Agency Policies AS-1203, Section III (I) (2), Pg. 6, and AS-401, Section III (F) (5) (1), Pg. 11, address this provision. The agency memo stated, "Despite the state provisions not allowing for cross-gender viewing and searches, the Department has trained a percentage of the direct supervision staff in Detention and 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 records were requested and provided to the auditor for review. The training records, dated August 2016, reflected security and medical staff had completed this training. Ten of the staff interviewed reported they are only permitted to conduct pat-down searches on same gender residents. One of the randomly selected staff reported receiving training consistent with this provision. 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. 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, which exceeds the requirements of this provision.

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 Policies AS-902, Section III (D) (8), Pg. 3, (F-G), Pgs. 5-6, and 5-DS-23, Section III (J), Pg. 7, 8-DS-28, Section III (G), Pg. 3. Interpreter Services for Deaf & Hard of Hearing Brochure, PREA Brochure, PREA Posters, Resident Handbook, Resident Record.

INTERVIEWS:
Chief Juvenile Probation Officer
At the time of the audit, there was only one LEP resident (Spanish) available to be interviewed.

FINDINGS:
Agency Policy AS-902, Section III (D) (8), Pg. 3, (F-G), Pgs. 5-6, 5-DS-23, Section III (J), Pg. 7, and 8-DS-28, Section III (G), Pg. 3, 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.
Staff reported the PREA posters, PREA brochures and resident handbooks are available in English and Spanish, bilingual staff are hired, translation for parents is also provided, bilingual staff are compensated, sign-language services are also available, and AISD teachers are special-education instructors.
At the time of the onsite audit, there was only one LEP resident available to interview. The resident reported not receiving some of the required educational information. The resident did report receiving information on the facility's rules against sexual abuse and sexual harassment. The auditor requested the resident's file and noted the Spanish translated forms of the resident education information had been signed by the resident acknowledging receipt of the information during intake. 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. PREA Brochure, PREA Posters, and Resident Handbook.

INTERVIEWS:
At the time of the audit, there was only one LEP resident (Spanish) available to be interviewed.

FINDINGS:
Agency Policy AS-902, Section III (G) (2), Pgs. 5-6, addresses this provision. The PREA Brochure, PREA Posters, and Resident Handbook are available in Spanish. Multiple staff have been identified as bilingual and are available as needed. At the time of the audit, there was only one LEP resident. The resident reported not receiving some of the required educational information at intake. The resident did report receiving information on the facility's rules against sexual abuse and sexual harassment. The auditor requested the resident's file and noted the Spanish translated forms of the resident education information had been signed by the resident acknowledging receipt of the information during intake. Additionally, the resident's records reflected a psychological evaluation had been conducted within the same time period as the onsite audit. The resident had been admitted into the facility two days prior to the onsite audit.

115.316(c)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-903, Section III (C) (1), and (D) (2) (b), Pgs. 4-5, and 4-DS-11, Section III (C) (1), Pgs. 4-5.

INTERVIEWS:
Random Sample of Staff
At the time of the audit, there was only one LEP resident (Spanish) available to be interviewed.

FINDINGS:
Agency Policies AS-903, Section III (C) (1), and (D) (2) (b), Pgs. 4-5, and 4-DS-11, Section III (C) (1), Pgs. 4-5, address this provision. Multiple staff have been identified and can translate in Spanish. The 11 staff interviewed reported they would never use residents to interpret for another resident and that there was always sufficient staff to interpret. At the time of the audit, there was only one limited English proficiency (LEP) speaking resident (Spanish only) available to be interviewed. The resident reported not receiving some of the required educational information. The resident did report receiving information on the facility's rules against sexual abuse and sexual harassment. The auditor requested the resident's file and noted the Spanish translated forms of the resident education information had been signed by the resident acknowledging receipt of the information during intake.

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) (g-i), Pgs. 3-4, and AS-209, Section I (B) (7), Pg. 2. Agency Forms. Employee Files

FINDINGS:
Agency Policies AS-203, Section III (F) (3) (g-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 23 randomly selected staff (17), volunteer (3), and contract (3) staff HR files indicated timely criminal background checks, all within the past five 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 the application process and supplemental questions, the requirement for a new criminal history check for staff applying for a promotion, and criminal background checks for contract staff are strategies utilized by the agency to detect incidents of sexual harassment. 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) (3 and 5), Pgs. 3-4. Employee Files.

INTERVIEWS:
Administrative (Human Resources) Staff

FINDINGS:
Agency policy AS-203, Section III (F) (3 and 5), Pg. 3-4, addresses this provision. A review of 23 (staff -17, volunteer -3, and contract - 3) randomly selected staff HR files indicated timely criminal background checks, and child abuse registry checks. The auditor interviewed the Administrative (Human Resources) Staff. Staff reported criminal background records and child abuse registry checks are conducted on all employees and contractors. New automatic criminal background checks are conducted when staff reach their two-year recertification date, and for any individual promoted. Additionally, reference checks are conducted by contacting prior institutional employers.

115.317(d)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-203, Section II, Pg. 1, Section III (D) (4), Pg. 2, and (F) (3) (j), Pg. 4. Contractor Files.

INTERVIEWS:
Administrative (Human Resources) Staff

FINDINGS:
Agency Policies AS-203, Section II, Pg. 1, Section III (D) (4), Pg. 2, and (F) (3) (j), Pg. 4, address the elements of this provision. Agency policy defines staff to include interns, volunteer, and 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 three (3) contract staff, and that AISD provides 15 contract teachers. A review of 23 randomly selected staff (17), volunteers (3), and contract (3) staff HR files indicated timely criminal background checks and child abuse registry checks. A review of three (3) contract teacher HR files indicated timely child abuse registry checks were conducted. The auditor interviewed the Administrative (Human Resources) Staff. Staff reported criminal background records and child abuse registry checks are

conducted on all employees and contractors.

115.317(e)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-203, Section III (F) (7), Pg. 4. Staff and Contractor HR files.

INTERVIEWS:
Administrative (Human Resources) Staff

FINDINGS:
Agency Policy AS-203, Section III (F) (7), Pg. 4, 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 23 randomly selected staff (17), volunteer (3), and contract (3) staff HR files indicated timely criminal background checks, all completed within the past five 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 TCIC, NCIC, the FAST with DPS, the Child Abuse Registry, FBI Report (National Background Check) Driver's License Check, and Child Support checks are conducted on all employees and contractors. A review of the agency policy and HR files, and staff interviews indicate the agency has conducted criminal background records and child abuse registry checks on all staff required to maintain certification 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 Policies AS-203, Section III (F) (1) and (7) (b), Pgs. 3-4, and AS-209, Section III (B) (11), Pg. 3. Staff HR Files.

INTERVIEWS:
Administrative (Human Resources) Staff

FINDINGS:
Agency Policies AS-203, Section III (F) (1) and (7) (b), Pgs. 3-4, and AS-209, Section III (B) (11), Pg. 3, address this provision. 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. All 17 staff HR files reviewed indicated the forms had been signed. Staff reported all staff had already signed the forms, which were filed in each employee's HR file. A signed form is required for new and promoted staff, as well as part of the employee evaluation process. A review of agency policies and staff 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. Affirmative Duty to Disclose Form

FINDINGS:
Agency Policies AS-203, Section III (F) (1), Pg. 3, and AS-209, Section I (B) (11), Pg. 3, address this provision. The form provides for a "material omissions" clause.

115.317(h)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-203, Section III (F) (7) (c), Pg. 4. PREA Information Request

INTERVIEWS:
Administrative (Human Resources) Staff

FINDINGS:
Agency Policy AS-203, Section III (F) (7) (c), Pg. 4, addresses this provision. Staff reported a request had not been received but would disclose the information as it pertained to the employee. Staff reported a Duty to Disclose would be secured from the potential new employer. During the post-audit phase, an inquiry from a prospective employer was received by the agency. Documentation was provided reflecting the agency responded to the prospective employer in accordance with this provision. A review of agency policy, supporting documentation, and staff interview indicate the practice is in place and meets the requirements of this provision.

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.

INTERVIEWS:
Chief Juvenile Probation Officer
Division Director of Detention Services

FINDINGS:
The agency reported it has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012. Staff reported plans are underway to expand across the street by adding a new building.

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. Detention Services Annual Staffing Plan.

INTERVIEWS:
Chief Juvenile Probation Officer
Assistant Chief Juvenile Probation Officer
Division Director of Detention Services

FINDINGS:
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. Staff presented documented ongoing efforts to identify the business and technical requirements necessary for the video monitoring technology upgrade of the facility. The Detention Services Annual Staffing Plan, dated November 15, 2016, includes plans to enhance the monitoring technologies at the facility. Funds have been requested and approved specifically for the video surveillance system to enhance the current camera system and add recording capabilities. Department representatives have been working actively with the Travis County Purchasing and ITS to move forward with the project as soon as possible. The auditor strongly recommended the video monitoring technology upgrades include audio capacity, especially in the common areas, and adequate memory/storage capacity.

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; AS-217, Section I, Pg. 1; and AS-217B, Section I, Pg. 1. The agency reported it oversees administrative investigations and the Travis County Sheriff's Office oversees 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; AS-217, Section I, Pg. 1; and AS-217B, Section I, Pg. 1, address this provision. Staff interviewed indicated a clear knowledge of their responsibilities as potential first responders and knowledge of agency policies and staff roles and responsibilities pertaining to investigations of allegations of sexual abuse.. A majority of staff interviewed knew who they would report the incident to.

115.321(b)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-905, Section III (B) (3) (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) (1) (a), Pg. 1, and (B) (2-3), Pgs. 2-3. 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:
SAFE/SANE Staff

FINDINGS:
Although policy is not required, Agency Policy AS-905, Section III (A) (1) (a), Pg. 1, and (B) (2-3), Pgs. 2-3, 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 victim advocate would be made available to accompany the resident through the forensic exam and investigative interviews 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 (A) (1) (a), Pg. 2. Memorandum of Understanding (MOU) with SafePlace - Travis County Domestic Violence and Sexual Assault Survival Center.

INTERVIEWS:
PREA Compliance Manager
During the onsite audit, there were no residents who had reported a sexual abuse, therefore no interview was conducted specific to this provision.

FINDINGS:
Although policy is not required, Agency Policy AS-905, Section III (A) (1) (a), Pg. 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. Staff reported an MOU has been entered with SafePlace to ensure properly trained staff assist a resident through the process and the agency has 24-hour access to this service. The MOU includes the responsibilities the agency and provider are to follow. 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.

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.

INTERVIEWS:
PREA Compliance Manager
During the onsite audit, there were no residents who had reported a sexual abuse, therefore no interview was conducted specific to this provision.

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 upon request from the resident. Staff reported if the resident requested, a victim advocate would accompany the victim. Staff added that if a resident did not know to ask for the victim advocate, the resident would be told of the service of the victim advocate who could be with them during the examination or as needed. 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.

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

FINDINGS:
The agency provided email documentation, dated April 26, 2016, 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:
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:
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 Policy AS-217B, Section III (D), Pg. 3. The agency reported it oversees administrative investigations and the Travis County Sheriff's Office oversees the criminal investigations. The agency reported there were no allegations of sexual abuse or sexual harassment received in the past 12 months. Investigative File.

INTERVIEWS:
Chief Juvenile Probation Officer

FINDINGS:
Agency Policy AS-217B, Section III (D), Pg. 3, addresses this provision. The agency reported it oversees administrative investigations and the Travis County Sheriff's Office oversees the criminal investigations. The agency reported there were no allegations of sexual abuse or sexual harassment received in the past 12 months. The auditor requested to see an investigative file that was outside the 12 month period, which was provided and reviewed. A review of the investigative file reflects the investigation was closed within one month of the date of the allegation.

Staff reported an investigation would be completed for all allegations of sexual abuse and sexual harassment. Staff reported, once an allegation is made, staff is trained to take immediate staps to respond the the alleged victim's needs and report the incident. Law enforcment and TJJD would be notified within the required timeframes and staff would be required to submit a written report before the end of shift. Administration would be notified immediately, and the General Counsel would assign an investigator. The investigator would review all reports and information. Completed reports of all investigations are required. 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) (4), Pg. 4 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) (4), Pg. 4 and (C) (1), Pg. 5, addresses this provision. A review of the agency policy, 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.

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:
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:
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-901, Section III (F), Pg. 10, AS-902, Section III (C), Pg. 3; AS-401, Section III (F) (5), Pgs. 10-11. Agency curriculum. Staff training records.

INTERVIEWS:
Random Sample of Staff

FINDINGS:
Agency Policies AS-901, Section III (F), Pg. 10, AS-902, Section III (C), Pg. 3; AS-401, Section III (F) (5), Pgs. 10-11, address this provision. The agency policy and curriculum address all the required topics. The auditor interviewed 11 randomly selected staff. Staff interviewed acknowledged attending and participating in the PREA training and confirmed the required topics were covered during the training. A review of the agency policy, training curriculum, 17 staff training records, and staff interviews demonstrate PREA related training is conducted and staff complete the training.

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 receive the same trained to work with all residents (males and females) in the facility.

115.331(c)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-401, Section III (F) (5), Pgs. 10-11, AS-901, Section III (F), Pg. 10, AS-902, Section III (C), Pg. 3. The agency reported 83 staff who have contact with residents are trained on the PREA topic requirements. Staff training records.

FINDINGS:
Agency Policies AS-401, Section III (F) (5), Pgs. 10-11, AS-901, Section III (F), Pg. 10, AS-902, Section III (C), Pg. 3, address this provision. Agency policy requires staff receive PREA related training during orientation and on an annual basis. The auditor reviewed 17 randomly selected staff training records. A review of the randomly selected staff 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, Court Clerks, Casework Managers, 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:
Although agency policy is not required, Agency Policy AS-401, Section III (G), Pg 12, addresses this provision. An initial review of the acknowledgement forms indicated that on some occassions the training staff had reverted to the old form. The PREA Coordinator immediately alerted staff and instructed the revised form initiated last year be utilized. The auditor requested and the agency provided supporting documentation indicated the new form continued to be used since the onsite audit visit was conducted. The agency maintains the signed acknowledgement forms which affirms the trainees understand the training they have received. Through staff interviews, it was made clear to the auditor 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 Policies AS-901, Section I (B), Pg. 1, and Section III (F), Pg. 10, AS-902, Section I (I), Pg. 2, and Section III (C), Pg. 3; and AS-1001, Section III (E) (2-3), Pgs. 5-6, and (F) (2), Pg. 6. Volunteer/Intern Handbook 2016. Volunteer and contract staff training records. The agency reported having 19 volunteers and contractors that have contact with residents.

INTERVIEWS:
Volunteers and Contractors

FINDINGS:
Although not required, Agency Policies AS-901, Section I (B), Pg. 1, and Section III (F), Pg. 10, AS-902, Section I (I), Pg. 2, and Section III (C), Pg. 3; and AS-1001, Section III (E) (2-3), Pgs. 5-6, and (F) (2), Pg. 6, address this provision. The Volunteer/Intern Handbook 2016, and volunteer (3) and contract staff (3) training documentation was reviewed. Training documentation reflected training events held specifically for school contract staff. The auditor interviewed four (4) randomly selected volunteers and contractors. 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 Policies AS-902, Section I (I), Pg. 2, and Section III (C), Pg. 3, and AS-1001, Section III (E) (2-3) and (15), Pg. 6. Volunteer/Intern Handbook 2016.

INTERVIEWS:
Volunteers and contractors

FINDINGS:
Although not required, Agency Policies AS-902, Section I (I), Pg. 2, and Section III (C), Pg. 3, and AS-1001, Section III (E) (2-3) and (15), Pg. 6, address this provision. The agency's Volunteer/Intern Handbook 2016 addresses the zero tolerance policy on page 34. The auditor interviewed four randomly selected volunteers and contractors. 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 Policies AS-902, Section I (I), Pg. 2, and Section III (C), Pg. 3, and AS-1001, Section III (A) (5), Pg. 2. Signed Volunteer/Intern and Contractor Acknowledgement Forms.

FINDINGS:
Although not required, Agency Policies AS-902, Section I (I), Pg. 2, and Section III (C), Pg. 3, and AS-1001, Section III (A) (5), Pg. 2, address this provision. 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) (3-4), Pg. 6. Resident Handbook (English and Spanish). Brochures (English and Spanish). Resident Files. The agency reported 1,702 residents were admitted and provided with the required PREA information at intake during the past 12 months.

INTERVIEWS:
Intake Staff
Random Sample of 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) (3-4), Pg. 6, address this provision. Staff reported the orientation packet contains all the PREA related information which is provided to all the residents during the intake process and 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. A majority of the residents interviewed reported being provided the PREA information during intake. At the time of the onsite audit, there was only one LEP resident available to interview. The resident reported not receiving some of the required educational information during intake. The auditor requested the resident's file and noted the Spanish translated forms of the resident education information had been signed by the resident acknowledging receipt of the information during intake. A review of 10 case files reflected all residents were provided the initial education required on the same day of admission during intake.

115.333(b)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-902, Section III (G) (1, and 3-4), Pg. 6. Resident Files.

INTERVIEWS:
Intake Staff

Random Sample of Residents

FINDINGS:
Although not required, Agency Policy AS-902, Section III (G) (1, and 3-4), Pg. 6, addresses this provision. A review of 10 case files reflected residents were provided the comprehensive education within 10 days of intake. Staff reported residents are provided information at intake and in the unit. A majority of the inmates reported receiving PREA related information. A review of 10 case files reflected all residents were provided the comprehensive education information. Comprehensive education classes are conducted on a weekly basis (every Saturday) in each occupied housing unit to ensure all residents were provided the required information. Completed group sign-in sheets reflecting the names of all residents are maintained for documentation purposes.

115.333(c)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-902, Section III (G), Pg. 5-7. Resident Files.

INTERVIEWS:
Intake Staff

FINDINGS:
Agency Policy AS-902, Section III (G), Pg. 5-7, addresses this provision. A review of 10 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 during group on weekends.

115.333(d)
POLICY AND DOCUMENT REVIEW:
Agency's Policy AS-902, Section III (G) (2, and 3-4) (b), Pg. 5-6. Resident Handbooks, PREA brochures, and PREA posters. Interpreter Services for Deaf & Hard of Hearing Brochure.

FINDINGS:
Agency's Policy AS-902, Section III (G) (2, and 3-4) (b), Pgs. 5-6, 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) (4) (b), Pg. 6. Resident Files. Acknowledgement of Receipt of Orientation Information and Materials Form and Detention Services PREA Group Sign in Sheet

FINDINGS:
Although not required, Agency's Policy AS-902, Section III (G) (4) (b), Pg. 6, addresses this provision. 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 Detention Services PREA Group Sign in Sheet is used to document the names of the residents that participate in the weekly Saturday PREA education classes. A review of 10 case files reflected all residents had participated and been provided the required PREA related information and education.

115.333(f)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-902, Section III (G) (4) (a and c), 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) (4) (a and c), Pg. 6, addresses this provision. PREA educational and informational materials, including the Resident Handbook and PREA posters are continuously 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.

INTERVIEWS:
Investigative Staff

FINDINGS:
Agency Policy AS-217B, Section III (C), Pg. 2, addresses this provision. Training documentation (faculty bios, training agenda, training modules, and PREA general and specialized investigator training records sign-in sheets) reflected the investigators had completed the general PREA training and the specialized investigator training. Staff interviewed reported receiving the required investigative training in 2013 during a two and a half day training event from the Moss Group and additional training in 2014 on the manual and agency policies. A review of an investigator's training record reflected the general PREA training and specialized training had beed received.

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

INTERVIEWS:
Investigative Staff

FINDINGS:
Agency Policy AS-217B, Section III (B-C), Pg. 2. addresses this provision. The training module included all of the required topics. Staff 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 12 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 training records reflect all 12 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 had received the required specialized investigator training.

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

FINDINGS:
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. The agency reported there were 18 medical and mental health care practitioners who received the required specialized training. Training documentation. : randomly selected training files, sign-in sheets.

INTERVIEWS:
Medical and Mental Health Staff

FINDINGS:
Agency Policy AS-401, Section III (F) (3) (c) (2), Pg. 9, addresses this provision. A review of three (3) medical staff training records and additional training sign-in sheets indicated medical and mental health staff participated in the specialized medical and mental health PREA training. Staff interviewed reported receiving the required specialized training.

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

INTERVIEWS:
Medical Staff

FINDINGS:
The agency reported the facility's medical staff do not conduct forensic exams. 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.

FINDINGS:
Although not required, Agency Policy AS-401, Section III (G), Pg. 12, addresses this provision. Training documentation (three training files, sign-in sheets) reviewed indicated medical and mental health staff, completed the specialized PREA training.

115.335(d)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-401, Section III (F) (5), Pg. 10. Training records.

FINDINGS:
Although not required, Agency Policy AS-401, Section III (F) (5), Pg. 10, addresses this provision. Training documentation (three training files, sign-in sheets) reviewed reflected medical and mental health staff completed the required 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 5-DS-23, Section III (C), Pg. 2, and (M), Pg. 8, and AS-905, Section III (A), Pg. 1. Resident files.

INTERVIEWS:
Staff Responsible for Risk Screening: Medical and Mental Health Staff
Random Sample of Residents

FINDINGS:
Agency policies 5-DS-23, Section III (C), Pg. 2, and (M), Pg. 8, and AS-905, Section III (A), Pg. 1, address this provision. Ten juvenile files were

reviewed. All of the case files reflected the screening process was completed on the same date of arrival. Staff interviewed reported residents are screened on the same date of admission and that they would continue to do follow-up with a resident periodically. Staff reported if any risk factors were to be detected, they would reassess the resident. Most of the residents interviewed had been at the facility less than two weeks. Two residents reported they had been at the facility for more than two weeks and one reported being at the facility for four months. Several of the residents interviewed verified staff do conduct periodic follow-up questions after the intake process is completed. Three of the resident files reviewed indicated a followup screening was required and was conducted. 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 and a followup is conducted.

115.341(b)
POLICY AND DOCUMENT REVIEW:
Detention Housing Screening Form and Detention Housing Screening Review Form.

FINDINGS:
The agency uses two objective screening instruments: the Detention Housing Screening Form and Detention Housing Screening Review Form for follow-up reassessments

115.341(c)
POLICY AND DOCUMENT REVIEW:
Detention Housing Screening Form and Detention Housing Screening Review Forms.

INTERVIEWS:
Staff Responsible for Risk Screening: Medical and Mental Health Staff

FINDINGS:
The agency's Detention Housing Screening Form and Detention Housing Screening Review Forms 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: Medical and Mental Health Staff

FINDINGS:
Staff reported the information is ascertained through resident interviews and other individuals.

115.341e)
POLICY AND DOCUMENT REVIEW:
Agency policy AS-905, Section III (A) (5), Pg. 2.

INTERVIEWS:
PREA Coordinator
PREA Compliance Manager
Staff Responsible for Risk Screening: Medical and Mental Health Staff

FINDINGS:
Agency policy AS-905, Section III (A) (5), Pg. 2, addresses this provision. Intake staff interviewed reported medical and mental health records are maintained in their offices. Staff reported shift supervisors are provided information on a need-to-know basis.

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 5-DS-23, Section III (C), PG. 2. Detention Housing Screening and Detention Housing Screening Review Forms.

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

FINDINGS:
Although not required, Agency Policy 5-DS-23, Section III (C), PG. 2, addresses this provision. Agency forms, the Detention Housing Screening Form, Pg. 2, and Detention Housing Screening Review Form, reflect and document the housing assignments. Staff reported medical staff use the housing screener and certain information triggers notification to the shift supervisor. Assessments are made to keep residents safe and allow the residents to privide input. Accomodations can be made if an resident wants to be in the housing unit based on the gender they identify with.

115.342(b)
POLICY AND DOCUMENT REVIEW:
Agency Policy 10-DS-8, Section III (A) (3), Pgs. 2-3, and (E), Pg. 5. The agency reported there were no residents at risk of sexual victimization who were placed in isolation in the past 12 months.

INTERVIEWS:
Division Director of Detention Services
Medical and Mental Health Staff
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 or security staff 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 10-DS-8, Section III (A) (3), Pgs. 2-3, and (E), Pg. 5, addresses this provision. Staff reported isolation is used as a last resort and staff look for other options, even if it means opening another unit, plus a resident would be assigned staff on a 1:1 ratio. Staff reported no resident had been placed in isolation under this circumstance in the past 12 months. Medical and mental health staff reported this type of isolation has not happened, but any resident placed in isolation would receive daily visits or more frequent as needed.

115.342(c)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-1203, Section III (E), Pg. 4 and (E) (1) (c), Pg. 5.

INTERVIEWS:
PREA Coordinator
PREA Compliance Manager
During the onsite audit, there were no lesbian, gay, bisexual, transgender, or intersex 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) (1) (c), Pg. 5, addresses this provision. Staff 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 3), Pg. 5.

INTERVIEWS:
PREA Compliance Manager
During the onsite audit, there were no lesbian, gay, bisexual, transgender, or 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 3), Pg. 5, addresses this provision. Staff reported any action would be initiated by medical. Subsequently, the Division Manager, Shift Supervisor and Probation Officer would act based on the safety of the resident.

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

INTERVIEWS:
PREA Compliance Manager
Staff Responsible for Risk Screening: Medical and Mental Health Staff

FINDINGS:
Although not required, Agency Policy AS-1203, Section III (F) (6), Pg. 6, addresses this provision. Staff interviewed reported transgender and intersex residents would be reassessed at least twice each year to review any threats to safety in consideration of 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
Staff Responsible for Risk Screening: Medical and Mental Health Staff
During the onsite audit, there were no transgender or 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
Staff Responsible for Risk Screening: Medical and Mental Health Staff
During the onsite audit, there were no transgender or intersex residents housed at the facility, therefore no resident was interviewed specific to this provision.

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 reported residents are only allowed to shower separately.

115.342(h)
POLICY AND DOCUMENT REVIEW:
Agency Policy 10-DS-8, Section III (A) (2), Pg. 2. The agency reported there have been no PREA related incidents involving the isolation of any resident in the past 12 months.

FINDINGS:
Agency Policy 10-DS-8, Section III (A) (2), Pg. 2, addresses this provision. 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 10-DS-8, Section III (E) (5), Pg. 5. TCJPD Detention Services Serious Incident Report Form. 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 were not interviewed due to the agency reporting there were no residents isolated specific to this provision in the past 12 months.
During the onsite audit, there were no residents in isolation (for risk of sexual victimization/who allege to have suffered sexual abuse), therefore no resident was interviewed specific to this provision.

FINDINGS:
Agency Policy 10-DS-8, Section III (E) (5), Pg. 5, addresses this provision. A review of the agency policy indicates a review by the Director of Detention 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 24 hours. This policy would exceed the 30-day review required by this provision.

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) (2), Pg. 3. Resident Handbook. Grievance Form. Writing Instruments.

INTERVIEWS:
Random Sample of Staff
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) (2), Pg. 3, addresses this provision. The 11 staff interviewed reported residents have several options available to report an allegation: grievance form; call the hotline number; tell staff (including a counselor, or medical), and his or her parents, anonymously, and privately. Residents interviewed reported they could make a report to staff (supervisor, probation officer, counselor), tell police, use a grievance form, tell parent, call the hotline.. 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) (6), Pg. 7; and 4-DS-11, Section III (A) (1) (c), Pg. 3. PREA Posters. Agency policy states that residents are not detained solely for civil immigration purposes.

INTERVIEWS:
PREA Compliance Manager
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) (6), Pg. 7; and 4-DS-11, Section III (A) (1) (c), Pg. 3, address this provision. Staff reported residents could use the grievance procedure, call TJJD Hotline or SafePlace, or tell staff (medical, PREA Compliance Manager, or Deputy Director. Residents reported they would tell family (parent, grandparents, siblings), their probation officer, attorney, Child Protective Services (CPS) or Court Appointed Specialized Advocate (CASA) worker, and could do it anonymously by using a grievance form. Most residents reported they were aware they could make reports anonymously. 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 (A) (2), Pg. 3, and (C) (4), Pg. 7, AS-903, Section III (A) (1-2), Pg. 3-4, and 4-DS-11, Section III (A), Pg. 3.

INTERVIEWS:
Random Sample of Staff
Random Sample of Residents

FINDINGS:
Agency Policies AS-901, Section III (A) (2), Pg. 3, and (C) (4), Pg. 7, AS-903, Section III (A) (1-2), Pg. 3-4, and 4-DS-11, Section III (A), Pg. 3, address this provision. Staff reported they would accept reports in writing, anonymously, verbally and through third parties, and that any reports received verbally would be documented immediately and by end of shift. Residents reported they could make reports anonymously, in writing, calling hotline, grievance, verbally, or through a parent, staff member, CASA worker, attorney, or probation officer.

115.351(d)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-901, Section III (A) (2), Pg. 3; and 4-DS-11, Section III (A) (1) (a), Pg. 3.

INTERVIEWS:
PREA Compliance Manager
During the onsite audit, there were no residents that had reported a sexual abuse incident, therefore no resident was interviewed specific to this provision.

FINDINGS:
Agency Policies AS-901, Section III (A) (2), Pg. 3; and 4-DS-11, Section III (A) (1) (a), Pg. 3, address this provision. Staff interviewed reported residents can make reports by submitting a grievance, by calling the hotline numbers posted, or tell any staff member.

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

INTERVIEWS:
Random Sample of Staff

FINDINGS:
Agency Policies AS-903, Section III (A) (3), Pg. 4; AS-401, Section III (F) (2) (e) (10), Pg. 7, address this provision. Staff reported they could privately report an incident through the hotline or anonymously, submit it in writing, contact Human Resources, their immediate supervisor or higher management.

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 Policy 9-DS-4, Section I, Pg. 1, and Section III (A) (11) (b). Memo. Resident Handbook.

FINDINGS:
Agency Policy 9-DS-4, Section I, Pg. 1, and Section III (A) (11) (b), addresses this provision. Agency Policy 9-DS-4, Section III (A) (11) (b), Pg. 2, 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.

Per agency memo submitted to the audit and dated March 29, 2017, "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 abuse, neglect or exploitation, to include sexual abuse and sexual harassment (ANE), that portion of the grievance will be administratively closed by the initiation of an administrative and/or criminal investigation. Any other element of the grievance will be addressed in accordance with the grievance policies.

The Department investigates all allegations of ANE and does not allow a resident to decline any third party invormation. If a resident reguses to cooperate in an investigation, the Department will continue to investigate the incident as much as necessary to determine if the allegation was founded, inconclusive or unfounded." The agency reported there have not been any resident or third party 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, 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:
Refer to 115.352(a)

FINDINGS:
A review of provision 115.352(a) has determined the agency is exempt from this standard and subsequent provisions 115.352(b-g) of this standard.

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
During the onsite audit, there were no residents that had reported a sexual abuse incident, therefore no resident was interviewed specific to this provision.

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. Some residents reported they were aware of SafePlace and others were not. Most reported they would prefer to talk with family or staff.

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

INTERVIEWS:
Random Sample of Residents
During the onsite audit, there were no residents that had reported a sexual abuse incident, therefore no resident was interviewed specific to this provision.

FINDINGS:
Agency Policy AS-905, Section III (E) (4), Pg. 4, addresses this provision. Residents interviewed reported they had never reported an incident of sexual abuse while at the facility and had not used the phone for this purpose. A few of the residents thought all calls are recorded. The auditor verified with staff that phone calls are not recorded.

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 Policy 12-DS-2, Section III (A), Pg. 2.

INTERVIEWS:

Director of Detention Services
PREA Compliance Manager
Random Sample of Residents
During the onsite audit, there were no residents that had reported a sexual abuse incident, therefore no resident was interviewed specific to this provision.

FINDINGS:
Agency Policy 12-DS-2, Section III (A), Pg. 2, addresses this provision. Staff reported residents are provided with reasonable and confidential access to their attorneys and reasonable access to their parents. A visitation room, including six (6) smaller adjacent rooms, allow for confidential conversations with an attorney are available. Visitations with attorneys have no restrictions. Staff reported phone calls are allowed every evening, and visitation hours are set for the following days: Wednesday, Saturday, and Sunday. Initial visitations are scheduled for Tuesdays. Residents reported they can call or visit with their attorneys and their communication is confidential, and they can call and/or visit with their parents. Several residents were very familiar with the visitation schedule.

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) (2), Pg. 3. PREA Posters and PREA Brochures

FINDINGS:
Although not required, Agency Policy AS-901, Section III (A) (2), 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. The PREA Brochure is provided to every resident during intake.

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-217, Section III (H) (1), Pg. 4, and AS-901, Section III (A), Pg. 3, and (C-D), Pgs. 5-9.

INTERVIEWS:
Random Sample of Staff

FINDINGS:
Agency Policies AS-217, Section III (H) (1), Pg. 4, and AS-901, Section III (A), Pg. 3, and (C-D), Pgs. 5-9, address this provision. All staff reported they would immediately report any knowledge, suspicion, or information regarding any allegation of sexual abuse or sexual harassment. Staff would also 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), Pg. 3.

INTERVIEWS:
Random Sample of Staff

FINDINGS:
Agency Policy AS-901, Section III (A), 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), Pg. 4.

INTERVIEWS:
Random Sample of Staff

FINDINGS:
Agency Policy AS-901, Section III (A) (8), 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 indicated they would disclose information regarding the incident to an immediate supervisor, law enforcement and the hotline.

115.361(d)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-901, Section II (B), Pg. 1, Section III (A) (5) (b), Pg. 4, and AS-902, Section III (G) (1), Pg. 5.

INTERVIEWS:
Medical and Mental Health Staff

FINDINGS:
Agency Policies AS-901, Section II (B), Pg. 1, Section III (A) (5) (b), Pg. 4, and AS-902, Section III (G) (1), Pg. 5, address this provision. Staff reported they complete the Informed Consent Form with Residents 18+ years of age, and per policy are notified of the staff's 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, Section III (C) (2) (b), Pgs. 6-7, and (C) (6), Pg. 8.

INTERVIEWS:
Division Director of Detention Services
PREA Compliance Manager

FINDINGS:
Agency Policy AS-901, Section III (C) (2) (b), Pgs. 6-7, and (C) (6), Pg. 8, addresses this provision. Staff listed the appropriate agencies to which allegations would be reported to, which included law enforcement, TJJD, DFPS, and agency upper management, plus the required reporting timeframes. The resident's caseworker would notify the parent or guardian at litem.

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

INTERVIEWS:
Division Director of Detention Services

FINDINGS:
Agency Policy AS-901, Section III (A) (3), Pg. 4, addresses this provision. Staff reported all allegations are reported directly to the designated facility 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 4-DS-11, Section III (B), Pg. 4. 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 Detention Services
Random Sample of Staff

FINDINGS:
Agency Policies AS-903, Section III (B), Pg. 4, and 4-DS-11, Section III (B), Pg. 4, address this provision. Staff reported immediate action would be taken if staff were to become aware of any resident being at substantial risk of imminent sexual abuse. Management staff reported the first thing to be done would be to separate the resident from the situation, such as assignment to a different unit, assess if there is a need for special services (medical and/or counseling) or bring in new resources, and determine the staffing levels pertaining to security and programming, and briefings between shifts. Supervisory staff would oversee these actions. Randomly selected staff reported immediate steps would be taken to remove the resident from the unit and report the incident to their supervisor in response 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), Pg. 9. The agency reported there had been one notification of an allegations that a resident was sexually abused or sexually harassed while confined at another facility. Notification.

FINDINGS:
Agency Policy AS-901, Section III (D), Pg. 9, addresses this provision. The facility provided a copy of an email documenting communication by the facility head notifying the the head of the facility where the alleged abuse occurred. The email indicated a report of the allegation had been made to the appropriate investigative agency. Supporting documentation was provided reflecting the Joint Commission, Department of Family and Protective Services (DFPS), and the Austin Police Department (APD) were notified on the same date the allegation was reported.

115.363(b)
POLICY AND DOCUMENT REVIEW:

Agency Policy AS-901, Section III (D), Pg. 9. Notification.

FINDINGS:
Agency Policy AS-901, Section III (D), Pg. 9, addresses this provision. The facility provided a copy of an email documenting communication by the facility head notifying the head of the facility where the alleged abuse occurred. The allegation had been reported the previous day. The email indicated the head of the facility had communicated via phone with the head of the facility where the alleged abuse occurred the following day in the morning, and the phone call conversation was followed by an email affirming the earlier phone call at 12:01 PM. This demonstrated the notification was made one day after the allegation was received and within the required 72 hour period.

115.363(c)
POLICY AND DOCUMENT REVIEW:
Notification.

FINDINGS:
The facility provided a copy of an email documenting communication by the facility head notifying the head of the facility where the alleged abuse occurred.

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
Division Director of Detention Services

FINDINGS:
Agency Policy AS-217, Section I, Pg. 1, addresses this provision. Staff reported no allegation had been received from another facility of an allegation occurring at the facility. Staff reported if an allegation were to be received, the PREA Coordinator would be notified, who would then notify the Chief Juvenile Probation Officer or Agency's General Counsel, who would initiate an investigation and the process outlined in policy would be followed: assign investigator; investigate; coordinate with law enforcement; if incident involved staff, take appropriate actions; notify alleged victim's parents; secure reports, and coordinate with appropriate facility head and PREA Coordinator.

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. 5-7, and 4-DS-11, Section III (D-F), Pgs. 5-7. The agency reported there had been no allegations that a resident was sexually abused in the past 12 months. Document: First Responder Duties Detention Services Assess - Respond - Stabilize.

INTERVIEWS:
Security Staff and Non-Security Staff First Responders. There were no allegations of resident sexual abuse, therefore no staff was interviewed specific to his provision.
During the onsite audit, there were no residents that had reported a sexual abuse incident, therefore no resident was interviewed specific to this provision.

FINDINGS:
Although not required, Agency Policies AS-903, Section III (D-F), Pgs. 5-7, and 4-DS-11, Section III (D-F), Pgs. 5-7, address this provision. A review of the document titled, "First Responder Duties Detention Services Assess - Respond - Stabilize" outlines in detail the steps staff are to follow when responding to an allegation, including notifications and documentation protocols. While conducting staff interviews, the auditor inquired on what steps staff would take if an allegation was made. Staff reported on the immediate actions they would take in responding to the needs of the alleged victim and making the proper notifications and documentation.

115.364(b)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-903, Section III (A) (1) (d), Pg. 3, and 4-DS-11, Section III (A) (1) (d), Pg. 3. The agency reported there had been no allegations that a resident was sexually abused in the past 12 months. Document: First Responder Duties Detention Services Assess - Respond - Stabilize

INTERVIEWS:
Security Staff and Non-Security Staff First Responders. There were no allegations of resident sexual abuse, therefore no staff was interviewed specific to this provision.
Random Sample of Staff

FINDINGS:
Agency Policies AS-903, Section III (A) (1) (d), Pg. 3, and 4-DS-11, Section III (A) (1) (d), Pg. 3, address this provision. Staff reported the following immediate steps would be followed: secure the victim; notify the supervisor, counselor and medical; notify the proper agencies: TJJD, and 911; and write the incident report. Non-security staff reported they would immediately notify the staff supervisor on the floor.

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. 6-8; and 4-DS-11, Section III (F), Pgs. 6-9. Documents: First Responder Duties Detention Services Assess - Respond - Stabilize; First Responder Duties Residential Services Assess - Respond - Stabilize.

INTERVIEWS:
Division Director of Detention Services

FINDINGS:
Agency Policies AS-903, Section III (F), Pgs. 6-8; and 4-DS-11, Section III (F), Pgs. 6-9, address this provision. A review of the document titled, "First Responder Duties Detention 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. The First Responder Duties Residential Services Assess - Respond - Stabilize document is the institutional plan for the Post-Adjudication facility.

Staff interviewed reiterated the protocols outlined in the agency's institutional plan and included information pertaining to the subsequent incident review process to ensure such incident does not occur again.

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-214, Section III (E), Pgs. 6-7. The agency reported the State of Texas is an at-will employment state. Document: Travis County Juvenile Court Department Statement of Understanding.

INTERVIEWS:
Chief Juvenile Probation Officer

FINDINGS:
Agency Policy AS-214, Section III (E), Pgs. 6-7, addresses this provision. The Travis County Juvenile Court Department Statement of Understanding Form instructs all applicants to sign and date the document. The document contains the following statement: "I understand that employment by Travis County is "at will" which means that either I or the County can terminate the employee relationship at any time, with or without prior notice. All employment is continued on this basis. I understand that no employee of the County other than Chief Juvenile Probation Officer has any authority, either in writing or orally, to alter the aforementioned." Staff reported the State of Texas is an at-will employment state and there is no collective bargaining agreement in existence or another agreement that would limit the agency's ability to remove alleged staff sexual abusers from contact with residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted.

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

FINDINGS:
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-904, Section III (G), Pgs. 5-6. The agency reported the Division Director of Detention Services with the responsibility of monitoring for possible retaliation.

FINDINGS:
Agency Policies AS-217, Section III (H), Pg. 3-4; AS-904, Section III (G), Pgs. 5-6, address this provision. Per memo dated March 29, 2017, the agency designates the Division Director of Detention Services with the responsibility of monitoring for possible retaliation and allows the Division Director to delegate this responsibility to another individual.

115.367(b)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-904, Section III (G) (1) (e), Pg. 5. The agency reported there had been no incidents of retaliation that occurred in the past 12 months.

INTERVIEWS:
Chief Juvenile Probation Officer
Division Director of Detention Services - Designated Staff Member Charged with Monitoring Retaliation. Since there were no incidents of retaliation reported in the past 12 months, staff were not interviewed on those questions specific to this provision.
During the onsite audit, there were no residents in isolation (for risk of sexual victimization/who alleged to have suffered sexual abuse) or residents who reported sexual abuse, therefore no resident was interviewed specific to this provision.

FINDINGS:
Agency Policy AS-904, Section III (G) (1) (e), Pg. 5, addresses this provision. Staff reported the resident would be separated from the alleged abuser until the matter is resolved. When an investigation is initiated, the individual making the report is told of their right to be safe and being able to report or file a complaint without fear of retaliation. Their is a zero tolerance and the agency will respond to protect staff and residents. Staff reported the process that would be followed and strategies used when monitoring for potential retaliation against both residents and staff. The

115.367(c)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-904, Section III (G) (1-3), Pgs. 5-6. The agency reported there had been no incidents of retaliation that occurred in the past 12 months.

INTERVIEWS:
Division Director of Detention Services - Designated Staff Member Charged with Monitoring Retaliation. Since there were no incidents of retaliation reported in the past 12 months, staff were not interviewed on those questions specific to this provision.

FINDINGS:
Agency Policy AS-904, Section III (G) (1-3), Pgs. 5-6, addresses this provision.
Staff reported in detail what they would look for when monitoring for retaliation for both residents and staff, including the possible outcomes if there is retaliation.

115.367(d)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-904, Section III (G) (2) (a), Pg. 6. The agency reported there had been no incidents of retaliation that occurred in the past 12 months.

INTERVIEWS:
Division Director of Detention Services - Designated Staff Member Charged with Monitoring Retaliation. Since there were no incidents of retaliation reported in the past 12 months, staff were not interviewed on those questions specific to this provision.

FINDINGS:
Agency Policy AS-904, Section III (G) (2) (a), Pg. 6, addresses this provision.

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

INTERVIEWS:
Chief Juvenile Probation Officer
Division Director of Detention Services

FINDINGS:
Agency Policy AS-904, Section III (G), Pg. 5, addresses this provision. Staff reported they would let individuals know their safety, protection, and confidentiality is very important and the agency has steps in place that will protect them. Staff will be advised of the Employee Assistance Program if they express a need for services. Staff reported in detail what they would look for when monitoring for retaliation for both residents and staff, including the possible outcomes if there is retaliation.

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

FINDINGS:
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 10-DS-8, Section II (E), Pg. 1, and Section III (E), Pg. 5-6. 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 Detention Services,
Staff who Supervise Residents in Isolation. There were no residents who alleged to have suffered sexual abuse who were placed in isolation in the past 12 months, therefore no staff were interviewed specific to this provision.
Medical and Mental Health Staff
During 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 10-DS-8, Section II (E), Pg. 1, and Section III (E), Pg. 5-6, addresses this provision. Staff reported isolation is used as a last resort and staff look for other options, even if it means opening another unit, plus a resident would be assigned staff on a 1:1 ratio. Staff reported no resident had been placed in protective custody in the past 12 months. Medical and mental health staff reported this type of isolation has not happened, but any resident placed in isolation would receive daily visits or more frequent as needed. Since there had been no reported protective custody isolation incidents, 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 Policy AS-217. The agency reported it oversees administrative investigations and the Travis County Sheriff's Office oversees criminal investigations.

INTERVIEWS:
Investigative Staff

FINDINGS:
Agency Policy AS-217, addresses this provision. Staff reported investigations are initiated immediately, within minutes or hours, and they have five (5) business days to complete the investigation. Staff reported third-party and anonymous reports are not treated any differently but may take longer based on how thorough or vague the information on the allegation might be.

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

INTERVIEWS:
Investigative Staff

FINDINGS:
Although not required, Agency Policy AS-217B, Section III (B-C), Pg. 2 addresses this provision. A review of the investigative staff training records indicated all investigative staff are trained in the required specialized investigative staff training. Staff reported receiving the required training.

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

INTERVIEWS:
Investigative Staff

FINDINGS:
Agency Policy AS-217B, addresses this provision. The agency reported, via a memo dated June 12, 2017, "All investigations involving staff and residents go through the Office of General Counsel as part of a thorough review process. As part of the review, General Counsel will prepare a preliminary finding letter to the Chief Juvenile Probation Officer (Chief) prior to her final review and determination of the outcome finding. As part of the review process, all prior complaints and reports of sexual abuse involving the suspected perpetrator/person of interest would be included in the correspondence provided to the Chief as required in PREA standard 115.371(c)." The agency reported there were no allegations of sexual abuse or sexual harassment received in the past 12 months. The auditor requested to see an investigative file that was outside the 12-month period, which was provided and reviewed. A review of the investigative file reflected the required supporting documentation was maintained in the files. Staff reported in detail the steps they would follow and information collected and documented during the course of the investigation, including coordination efforts with law enforcement. Staff reported they would go to General Counsel for guidance as needed. 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.

115.371(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.

115.371(e)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-217B Section III (J) (2) (a), Pg. 7. The agency reported there were no allegations of sexual abuse or sexual harassment received in the past 12 months.

INTERVIEWS:
Investigative Staff

FINDINGS:
Agency Policy AS-217B Section III (J) (2) (a), Pg. 7, addresses this provision. Staff reported the case would be staffed with General Counsel to determine whether the administrative investigation should proceed or not, if cooperating with law enforcement (evidence appears to support criminal prosecution).

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
During the onsite audit, there were no residents who reported sexual abuse at the facility, therefore no resident was interviewed specific to this provision.

FINDINGS:
Agency Policy AS-217B, Section III (E) (1), Pg. 4, and (F) (1), Pg. 5, addresses this provision. Staff reported all information would be considered and the investigation would be based on the preponderance of the evidence. Staff reported a polygraph examination would not be used.

115.371(g)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-217B, Section III (H), Pgs. 6-7. Investigative files.

INTERVIEWS:
Investigative Staff.

FINDINGS:
Agency Policy AS-217B, Section III (H), Pgs. 6-7, addresses this provision. The agency reported there were no allegations of sexual abuse or sexual harassment received in the past 12 months. The auditor requested to see an investigative file that was outside the 12-month period, which was provided and reviewed. A review of the investigative file reflected the required elements in this provision. Staff reported in detail the type of information included

in the reports and that everything is considered as part of the investigation including whether staff actions or failures to act contributed to the abuse, and also to see if they need to change the way they operate so there is not a repeat of the situation.

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 the agency reported there were no allegations of sexual abuse reported in the past 12 months. Staff interviewed reported they would cooperate with law enforcement.

115.371(i)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-901, Section III (C) (1), Pg. 5, and AS-217B, Section III (C) (4), pg. 2. The agency reported there were no allegations of sexual abuse reported in the past 12 months.

INTERVIEWS:
Investigative Staff

FINDINGS:
Agency Policies AS-901, Section III (C) (1), Pg. 5, and AS-217B, Section III (C) (4), pg. 2, address this provision. The agency reported there were no allegations of sexual abuse or sexual harassment received in the past 12 months. The auditor requested to see an investigative file that was outside the 12-month period, which was provided and reviewed. A review of the investigative file reflected the victim declined to pursue charges, specifying that the other individual did not have the mental capacity to understand his actions. Staff reported if they believe there is a potential for a criminal offense, they make immediate contact with law enforcement.

115.371(j)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-217, Section III (I), Pg. 4, and AS-906, Section II (D) (2) (e), Pg. 4. The agency reported there were no allegations of sexual abuse or sexual harassment received in the past 12 months.

FINDINGS:
Agency Policies AS-217, Section III (I), Pg. 4, and AS-906, Section II (D) (2) (e), Pg. 4, address this provision and requires investigation reports will be kept in perpetuity. Based on information from the previous PREA Audit Report, which indicated there had been two allegations of youth on youth abusive sexual contact - one in calendar year 2014 and one in 2015, the auditor requested to see one of the two investigative files that was outside the 12-month period. The auditor noted both files were available for review and selected and reviewed the 2015 investigative files.

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

INTERVIEWS:
Investigative Staff

FINDINGS:
Agency Policy AS-217B, Section III (E) (2), Pg. 4, addresses this provision. Staff reported they would move forward with the investigation, even if it means asking for staff to come in. Staff reported they would not stop the investigation.

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

FINDINGS:
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 Detention Services

PREA Coordinator
PREA Compliance Manager
Investigative Staff

FINDINGS:
Although not required, Agency Policies AS-904 Section III (B) (4), Pg. 2, and AS-217B Section III (J), Pg. 7, address this provision. Staff reported the General Counsel would oversee the tracking of the status of the investigation. Staff reported they would cooperate with outside investigative agencies as necessary, stay informed on the status of the investigation, and coordinate on how to proceed.

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-217B, Section I, Pg. 1.

INTERVIEWS:
Investigative Staff

FINDINGS:
Agency Policy AS-217B, Section I, Pg. 1, addresses this provision. The agency reported there were no allegations of sexual abuse or sexual harassment received in the past 12 months. The auditor requested to see an investigative file that was outside the 12 month period, which was provided and reviewed. A review of the investigative file indicated the proper standard was used in determining that the allegation were founded. 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 there had been no allegations of resident sexual abuse in the past 12 months.

INTERVIEWS:
Division Director of Detention Services and Investigative Staff.

FINDINGS:

Agency Policy AS-904, Section III (F) (1) (a), Pg. 4, addresses this provision and requires notification for both sexual abuse and sexual harassment investigations. The agency reported there were no allegations of sexual abuse or sexual harassment received in the past 12 months. The auditor requested to see an investigative file that was outside the 12 month period, which was provided and reviewed. A review of the investigative file reflected the resident departed the facility prior to the conclusion of the investigation. Staff reported being aware of the requirement the resident be notified whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. 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's requirements.

115.373(b)
POLICY AND DOCUMENT REVIEW:
The agency reported there had been no allegations of resident sexual abuse in the past 12 months.

FINDINGS:
The agency reported there were no allegations of sexual abuse or sexual harassment received in the past 12 months. The auditor requested to see an investigative file that was outside the 12-month period, which was provided and reviewed. A review of the investigative file reflected the resident departed the facility prior to the conclusion of the investigation, and that the victim declined to pursue charges, specifying that the other individual did not have the mental capacity to understand his actions, therefore no external investigative agency completed the investigation.

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

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

FINDINGS:
Agency Policy AS-904, Section III (F) (1) (c), 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.

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

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

FINDINGS:
Agency Policy AS-904, Section III (F) (1) (d), Pgs. 4-5, addresses this provision. The agency reported there were no allegations of sexual abuse or sexual harassment received in the past 12 months. The auditor requested to see an investigative file that was outside the 12-month period, which was provided and reviewed. A review of the investigative file reflected the resident departed the facility prior to the conclusion of the investigation, therefore there was no notification provided to the resident.

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

FINDINGS:
Agency Policy AS-904, Section III (F) (4), Pg. 5, addresses this provision. The agency reported there were no allegations of sexual abuse or sexual harassment received in the past 12 months. The auditor requested to see an investigative file that was outside the 12-month period, which was provided and reviewed. A review of the investigative file reflected the resident departed the facility prior to the conclusion of the investigation, therefore there was no notification provided to the resident.

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

FINDINGS:
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-214, Section III (C) (4), Pg. 2, and AS-904, Section III (D) (1), Pg. 3.

FINDINGS:
Although not required, Agency Policies AS-214, Section III (C) (4), Pg. 2, and AS-904, Section III (D) (1), 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 member, contractor, intern or volunteer from the facility that have violated agency sexual abuse or sexual harassment policies in the past 12 months. Document: Sample Employee Termination Letter.

FINDINGS:
Agency Policy AS-904, Section III (D) (1) (a), Pg. 3, addresses this provision. Since there have been no staff member, contractor, intern or volunteer from the facility that have violated agency sexual abuse or sexual harassment policies in the past 12 months, there was no documentation to review specific to this provision. The agency provided a Sample Employee Termination Letter, which indicated the process is in place in the event of the termination of a staff member in response to this provision. The auditor noted the Travis County Attorney's Office would get copied on this communication.

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 from the facility that have been disciplined, short of termination, 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 from the facility that have been disciplined, short of termination, for violation of agency sexual abuse or sexual harassment policies, 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 III (D) (2), Pg. 3. The agency reported there have been no staff from the facility that have been reported to law enforcement or licensing boards following their termination (or resignation prior to termination) for violating agency sexual abuse or sexual harassment policies in the past 12 months.

FINDINGS:
Agency Policy AS-904, Section III (D) (2), Pg. 3, addresses this provision. Per agency memo dated June 12, 2017, "… If a Department employee resigns or is terminated during the course of an ongoing investigation of sexual abuse or sexual harassment, General Counsel or designee will be in contact with the assigned TCSO investigator to inform him or her of the status of the indivudual's employment..." Since there have been no staff from the facility that have been reported to law enforcement or licensing boards following their termination (or resignation prior to termination) for violating agency sexual abuse or sexual harassment policies 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 I, Pg. 1, and Section III (D) (4), Pg. 3. The agency reported there have 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 Policy AS-901, Section I, Pg. 1, and Section III (D) (4), Pg. 3, addresses this provision. Per agency policy, contrcted program services staff and volunteers are included in the definition of staff. Per agency memo dated June 12, 2017, "… If a Department employee resigns or is terminated during the course of an ongoing investigation of sexual abuse or sexual harassment, General Counsel or designee will be in contact with the assigned TCSO investigator to inform him or her of the status of the indivudual's employment...." The agency reported there have 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:
Agency Policy AS-904, Section III (D) (4), Pg. 3. Document: Sample Letter of Termination

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 have 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 reported any allegations of sexual abuse or sexual harassment of residents by contractors or volunteers would result in the immediate removal of the contractor or volunteer, including removal from the contractor/volunteer list. Both volunteers and contractors would be prohibited from having further contact with residents. The agency provided a Sample Letter of Termination, which indicated the process is in place in the event of the termination of a volunteer in response to this provision.

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; AS-905, Section III (D) (3), Pg. 4; 10-DS-1, Section III (A) (3), Pg. 2 and (C) (1), Pg. 3; 10-DS-2, Section II (H), Pg. 2, and (F-G), Pgs. 7-9; The agency reported there have been no incident of resident-on-resident sexual abuse in the past 12 months. Resident Orientation Packet, Resident Handbook, Disciplinary Hearing Report Form.

FINDINGS:
Agency Policies AS-904, Section III (E), Pgs. 3-4; AS-905, Section III (D) (3), Pg. 4; 10-DS-1, Section III (A) (3), Pg. 2 and (C) (1), Pg. 3; 10-DS-2, Section II (H), Pg. 2, and (F-G), Pgs. 7-9, address this provision. The Resident Orientation Packet, Pgs. 3-4, and Resident Handbook, Pgs. 15-16, 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) (3), Pgs. 3; and 10-DS-8, Section III (A) (3) (d-f), Pg. 3. The agency reported there have been no residents placed in isolation as a disciplinary santion for resident-on-resident sexual abuse in the past 12 months.

INTERVIEWS:
Division Director of Detention Services

FINDINGS:
Agency Policies AS-904, Section III (E) (3), Pgs. 3; and 10-DS-8, Section III (A) (3) (d-f), Pg. 3, address this provision. The agency reported there have been no residents placed in isolation as a disciplinary santion for resident-on-resident sexual abuse in the past 12 months, therefore there was no documentation to review specific to this provision. Staff reported a resident on resident sexual abuse incident would be considered a major rule violation and could result in Safety Based Seclusion, based on the severity of the infraction. Staff reported they would consider whether the incident was intentional or accidental, as well as the resident's disciplinary history. Staff reported isolation is not 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) (a), Pg. 4. The agency reported there have been no residents placed in isolation as a disciplinary santion for resident-on-resident sexual abuse in the past 12 months.

INTERVIEWS:
Division Director of Detention Services

FINDINGS:
Agency Policies AS-904, Section III (E) (2), Pg. 3; and AS-905, Section III (D) (3) (a), Pg. 4, address this provision. The agency reported there have been no residents placed in isolation as a disciplinary santion for resident-on-resident sexual abuse in the past 12 months, therefore there was no documentation to review specific to this provision. Staff reported they would consider the resident's mental capacity or diagnosis when determining sanctions.

115.378(d)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-905, Section III (D), Pg. 4, and 10-DS-2, Section III (F), Pgs. 7-9.

INTERVIEWS:
Medical and Mental Health Staff

FINDINGS:
Agency Policies AS-905, Section III (D), Pg. 4, and 10-DS-2, Section III (F), Pgs. 7-9, address this provision. Staff 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. Staff reported they have two detention counselors available seven (7) days a week to offer services to the residents. One of the counselors is bilingual (Spanish). Staff reported both counselors identify ongoing services needed upon the resident's release. The auditor noted the agency's efforts to enhance the quality of the resident'sservices, even upon release, exceed the requirements of this provision.

115.378(e)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-904, Section III (E) (4), Pg. 3; and 10-DS-2, Section III (G), Pg. 9. 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 (G), Pg. 9, 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 III (E) (1) (e), Pg. 4, and AS-904, Section III (E) (1), Pg. 3.

FINDINGS:
Agency Policies AS-901, Section I, Pg. 1, AS-902, Section III (E) (1) (e), Pg. 4, and AS-904, Section III (E) (1), Pg. 3, 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.

115.381(a)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-905, Section III (A), Pgs. 1-2; and 8-DS-5, Section III (C), Pg. 2. 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), Pgs. 1-2; 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. A review of the resident files reflected the residents did receive a follow-up meeting with medical and mental health practitioners as required. Staff reported they make sure they follow-up immediately and doing a referral. Residents interviewed denied prior victimization. The auditor verified, through file review, the residents did receive medical/mental health follow-up services.

115.381(b)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-905, Section III (A) (2), Pg. 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) (2), Pg. 2, addresses this provision. Staff interviewed reported residents are referred to mental health staff for follow-up as soon as possible. A review of a randomly selected resident file indicated the resident had an allegation pending disposition before a juvenile court judge. The file reflected the resident did not receive a follow-up meeting with a mental health practitioner due to the case pending disposition.

115.381(c)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-902, Section III (F) (1), Pg. 5.

ONSITE REVIEW (TOUR OBSERVATIONS):
During the onsite tour, the auditor noted medical and mental health staff have designated office space where staff can privately interview residents. Medical and Mental Health records are maintained separately and information is shared on a need-to-know basis and according to policy.

FINDINGS:
Agency Policy AS-902, Section III (F) (1), Pg. 5, addresses this provision.

115.381(d)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-905, Section III (A) (6), Pg. 2. The agency reported there have been no instances in which consent was required to report an incident of abuse, neglect, or exploitation. 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) (3), Pg. 2; 8-DS-5; and 8-DS-28.

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

FINDINGS:
Although not required, Agency Policies AS-905, Section I, Pg. 1, and Section III (A) (3), Pg. 2; 8-DS-5; and 8-DS-28, address this provision. Staff 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.

115.382(b)
POLICY AND DOCUMENT REVIEW:
Agency Policy 8-DS-5. Medical services are available 24/7 at the facility. Mental health counselors provide treatment and counseling to residents.

INTERVIEWS:
Security Staff and Non-Security Staff First Responders. The agency reported there were no allegations of sexual abuse in the past 12 months, therefore no staff were interviewed specific to this provision.

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. Medical services are available 24/7 at the facility. Mental health counselors provide treatment and counseling.

115.382(c)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-905, Section III (B) (3) (c-d), Pg. 3. Sample Mental Health Log - Data Entry Table Form

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

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 through SafePlace.

115.382(d)
POLICY AND DOCUMENT REVIEW:
Agency Policies AS-905, Section III (B) (2), Pg. 2, and (C) (3), Pg. 3.

FINDINGS:
Although not Required, Agency Policies AS-905, Section III (B) (2), Pg. 2, and (C) (3), Pg. 3, 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. Medical services are available 24/7 at the facility. Mental health counselors provide treatment and counseling to residents.

115.383(b)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-905, Section III (B) (4) and (C) (4), Pg. 3. The agency reported there were no allegations of resident sexual abuse requiring medical treatment, follow-up services or referrals for continued care.

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

FINDINGS:
Although not required, Agency Policy AS-905, Section III (B) (4) and (C) (4), Pg. 3, addresses this provision. Staff interviewed reported in accordance with instructions from SafePlace, and per a doctor's directives, follow-up services would be matched with appropriate intervention services. Counseling staff will check in with the resident to see if the resident did access the follow-up services. Staff reported every youth is made aware of the counselor's availability.

115.383(c)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-905, Section III (A) (4), Pg. 2. The agency reported there were no allegations of resident sexual abuse requiring medical or mental health services.

INTERVIEWS:
Medical and Mental Health Staff

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

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

INTERVIEWS:
During the onsite audit, there were no residents who reported a sexual abuse at the facility, therefore no 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

During the onsite audit, there were no residents who reported a sexual abuse at the facility, therefore no 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 by SafePlace.

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:
During the onsite audit, there were no residents who reported a sexual abuse at the facility, therefore no 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. The agency reported there were no allegations of resident sexual abuse requiring treatment services.

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

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

115.383(h)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-905, Section III (D) (1-2), Pg. 3. The agency reported there were no allegations of resident sexual abuse requiring treatment services.

INTERVIEWS:
Medical and Mental Health Staff

FINDINGS:
Although not required, Agency Policy AS-905, Section III (D) (1-2), Pg. 3, addresses this provision. Staff noted they would secure the courts and attorney's consent due to the legal implications, as well as parental consent. Staff advised they would also have to determine any reporting requirements. Staff reported the evaluation would be part of the typical process, and an assessment would be conducted and staff would check in with the resident. Staff reported a link to services, including on-going services, would be made as appropriate.

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 no allegation of sexual abuse made in the past 12 months, therefore no administrative investigation of alleged sexual abuse was completed within the past 12 months.

FINDINGS:
Although not required, Agency Policy AS-906, Section II (A), Pg. 1, addresses this provision.

115.386(b)

POLICY AND DOCUMENT REVIEW:
Agency Policy AS-906, Section II (A) (1), Pg. 1. The agency reported there was no allegation of sexual abuse made in the past 12 months, therefore no administrative investigation of an alleged sexual abuse was completed nor required it be followed by a sexual abuse incident review within 30 days within the past 12 months.

FINDINGS:
Although not required, Agency Policy AS-906, Section II (A) (1), Pg. 1, addresses this provision.

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

INTERVIEWS:
Division Director of Detention 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, the Division Director of Detention Services, and other leadership and staff according to policy.

115.386(d)
POLICY AND DOCUMENT REVIEW:
Agency Policy AS-906, Section II (A) (3-4), Pgs. 1-3. Sample Incident Review Report Template. Investigative File.

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

FINDINGS:
Although not required, Agency Policy AS-906, Section II (A) (3-4), Pgs. 1-3, addresses this provision. Staff interviewed referenced all the elements needing to be considered, examined, and assessed. 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 Chief Juvenile Probation Officer, Division Director and PREA Compliance Manager. 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. Staff reported the last time the Incident Review Team met was over one year ago. The agency reported there were no allegations of sexual abuse or sexual harassment received in the past 12 months. The auditor requested to see an investigative file that was outside the 12 month period, which was provided and reviewed. A review of the investigative file reflected the required Incident Review Report was completed.

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) (2), Pg. 3. Database.

FINDINGS:
Although not required, Agency Policy AS-906, Section II (B) (2), Pg. 3, addresses this provision. 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. All sexual abuse and sexual harassment investigations are entered into the database.

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

FINDINGS:
Although not required, Agency Policy AS-906, Section II (B), Pg. 3, partially addresses this provision. The agency provided the Aggregated Datasheet for 2014, 2015, and 2016. The database is a comprehensive system designed to maintain various elements for the required data for sexual abuse allegations, plus 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. The database is a comprehensive system designed to maintain various elements for the required data for sexual abuse allegations, plus data for sexual harassment allegations, which exceeds the requirements of this provision.

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

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. The agency reported the Department of Justice has not requested the data.

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), Pgs. 3-4. Annual Reports

INTERVIEWS:
Chief Juvenile Probation Officer
PREA Coordinator
PREA Compliance Manager

FINDINGS:
Although not required, Agency Policy AS-906, Section II (D), Pgs. 3-4, addresses this provision. The agency's annual reports, dated March 2016, and

April 28, 2017, are posted on the agency's website.. A review of the annual reports reflected all the elements required by this provision. Staff reported on the process used to collect the data, maintaining the database, and removing personal identifiers to create the aggregated data. Staff reported in detail the process followed when reviewing the data and noting the trends, identifying problem areas and determining the best approach on the corrective action to take, and using the annual report as a guide for tracking as as part of the quality assurance process by incorporating it into training.

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

FINDINGS:
Although not required, Agency Policy AS-906, Section II (D) (2), Pg. 4, addresses this provision. The agency's annual reports, dated March 2016, and April 28, 2017, are posted on the agency's website. A review of the annual reports reflected all the elements required by this provision

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

INTERVIEWS:
Chief Juvenile Probation Officer

FINDINGS:
Although not required, Agency Policy AS-906, Section II (D) (2) (a), Pg. 4, addresses this provision. The agency's annual reports, dated March 2016, and April 28, 2017, are posted on the agency's website. A review of the annual reports reflected the signatures of the PREA Coordinator and the Chief Juvenile Probation Officer. Staff reported the Annual report is reviewed and approved by her.

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 is redacted. The PREA reports posted on the agency's website 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 reported access to any data is restricted to the Chief Juvenile Probation Officer, Assistant Chief Juvenile Probation Officer and the Compliance Unit staff. Access to the database is password protected.

115.389(b)
POLICY AND DOCUMENT REVIEW:

Agency Policy AS-906, Section II (C), Pg. 3 and (D) (2) (a), Pg. 4. Aggregated data on website and access to contract facilities' data.

FINDINGS:
Although not required, Agency Policy AS-906, Section II (C), Pg. 3 and (D) (2) (a), Pg. 4, addresses this provision. The data posted on the website includes the agency's data for Calendar Years 2014, 2015, and 2016. Staff reported they made an attempt to secure contract facility data in an electronic version via link but was unsuccessful with all of the facilities. The agency has arranged to secure the required data for each facility and make it available to the public upon request. The agency's posted information notes, "Aggregated sexual abuse data from other facilities with whom the Travis County Juvenile Probation Department contracts is available upon request by calling (512) 854-7001 and asking for the PREA Coordinator or emailing JuvCompliance@traviscountytx.gov"

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, 2015, and 2016.

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 PREA Coordinator is the primary person responsible for maintaining the sexual abuse database, which also includes sexual harassment data, and takes the lead for ensuring personal identifying information, is removed when aggregated data is requested. The data posted on the website includes data from Calendar Years 2014, 2015, and 2016.

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) 07-2-17

Auditor Signature Date