PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of Report: October 28, 2016

Auditor Information			
Auditor name: Lisa A. Capers			
Address: 4483 Wandering Vine Trail, Round Rock, TX 78665			
Email: lisacapersjd@gmail.com			
Telephone number: 512-658-0909			
Date of facility visit: April 5-8, 2016			
Facility Information			
Facility name: Lynn W. Ross Juvenile Detention Facility			
Facility physical address: 2701 Kimbo Road, Fort Worth, TX 76111			
Facility mailing address: *(if different from above)* Same as Above			
Facility telephone number:			
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: Ron Lewis, Facility Administrator			
Number of staff assigned to the facility in the last 12 months: 249			
Designed facility capacity: 120			
Current population of facility: 53			
Facility security levels/inmate custody levels: Secure, Pre-Adjudication, Maximum Security			
Age range of the population: 10-18			
Name of PREA Compliance Manager: Shelley Aguirre		**Title:** Quality Development Supervisor	
Email address: sjaguirre@tarrantcounty.com		**Telephone number:** 817-838-4600 x 0706	
Agency Information			
Name of agency: Tarrant County Juvenile Services			
Governing authority or parent agency: *(if applicable)* Tarrant County Juvenile Board			
Physical address: 2701 Kimbo Road, Fort Worth, TX 76111			
Mailing address: *(if different from above)* Same as Above			
Telephone number: 817-838-4600			
Agency Chief Executive Officer			
Name: Bennie Medlin		**Title:** Director of Juvenile Services	
Email address: bmedlin@tarrantcounty.com		**Telephone number:** 817-838-4600 x 4640	
Agency-Wide PREA Coordinator			
Name: Shelley Aguirre		**Title:** Quality Development Supervisor	
Email address: sjaguirre@tarrantcounty.com		**Telephone number:** 817-838-4600 x 0706	

AUDIT FINDINGS

Overview

The Prison Rape Elimination Act (PREA) on-site audit of the Tarrant County Juvenile Services' Lynn W. Ross Juvenile Detention Center in Fort Worth, Texas was conducted on April 5-8, 2016 by Lisa A. Capers, J.D. from Austin, Texas, a U.S. Department of Justice Certified PREA Auditor for juvenile facilities. On day one of the audit, the Auditor conducted an entrance conference, toured all areas of the facility and began interviews of random and specialized staff and random residents. On day two, the Auditor spent the entire day interviewing additional specialized staff and random and specialized residents. During day three, the Auditor completed the balance of all interviews and reviewed selected staff and resident files. On the last day of the on-site visit, the Auditor conducted an exit conference with the agency administration and staff to discuss preliminary findings and the subsequent audit processes and timeframes. The Auditor was treated with great hospitality during the visit by all the Tarrant County staff. Residents and staff were made readily available to the Auditor at all times for formal and informal interviews. The Auditor was provided unimpeded access to all parts of the facility during the on-site review. The level of preparation for the audit and the organization of the information provided to the Auditor in the *Pre-Audit Questionnaire (PAQ)* were excellent and the facility administration and staff had obviously made PREA compliance a high priority for the facility.

Pre-Audit Phase

On December 8, 2015, the Auditor provided the agency an overall audit timeline with all applicable dates and deadlines for the audit process and all its phases. Additionally, the Auditor provided the *Pre-Audit Questionnaire (PAQ)* for the facility to review and begin completion. On January 14, 2016, the first teleconference between the Auditor and the facility was held to discuss the timeline, overall process and any questions by the team. Additionally, the Auditor sent the facility the *PREA Audit Notices* (in English and Spanish) to be posted in the facility. At the request of the Auditor, audit notices were posted using colored or neon paper.

On January 24, 2016, the Auditor received date-stamped photographic evidence via email demonstrating the posting of these notices on January 22, 2016 at the building entrance, court entrances, detention entrance, housing units, and education classrooms. The audit notices were also posted on the agency website as verified by the Auditor: http://access.tarrantcounty.com/en/juvenile-services/division-listing/detention/detention-visitation-schedule/PREA.html. The facility was requested and agreed to keep all notices posted for six weeks after the on-site review. As of the date of this report, the Auditor had received no mail at the designated audit post office box.

The facility provided the completed *PAQ* to the Auditor along with supporting documents contained on a flash drive on February 29, 2016 preceding the on-site review portion of the audit. Pre-audit preparation by the Auditor included a thorough review of all documentation and materials submitted by the facility along with the data included in the completed *Pre-Audit Questionnaire*. The documentation reviewed included agency policies, procedures, forms, education materials, training curriculum, organizational charts, posters, brochures and other PREA related materials that were provided to demonstrate compliance with the PREA standards. This review prompted a series of questions that were reduced to writing by the Auditor and submitted to the PREA Coordinator on March 18, 2016 in the form of an *Issue Log* to which responses were requested. The Auditor and the facility had a second teleconference on March 18, 2016 to discuss the on-site portion of the audit and review logistical issues. Answers to the questions raised in the *Issue Log* were submitted by the facility management to the Auditor on March 24, 2016 and reviewed by the Auditor prior to the on-site review.

On March 21, 2016 the Auditor requested that the facility compile listings of key administrative personnel, specialized staff (e.g., contract administrator, human resources staff, medical and mental health staff, screening staff, intake staff, investigative staff, volunteers, contractors, etc.) and specialized residents (e.g., residents reporting abuse, disabled residents, LGTBI residents, etc.). The Auditor also requested the facility to identify a variety of files for review (e.g., new hires, employees promoted, employees disciplined, residents disciplined, investigations, etc.). The Auditor provided the facility with forms to use for this purpose. Once received from the facility, the Auditor

selected the staff and residents for interviews (i.e., administration, specialized and random staff and specialized residents still in the facility) as well as the files that were selected for review. This information was provided to the facility by the Auditor on March 31, 2016. On the first day of the on-site portion of the audit, the facility provided the Auditor with a listing of all residents in all housing units and the Auditor made the selection of random residents to be interviewed that represented all housing units. The Auditor also requested to review the corresponding resident files for all residents interviewed in the random sample.

On-Site Audit Phase

The Auditor arrived at the facility on Tuesday, April 5 at 8:30 a.m. and was shown to a private office in the administration area of the building near the juvenile courtrooms that functioned as home base during the audit. The Auditor began by conducting an entrance conference with facility administration at 9:00 a.m. After introductions and welcoming remarks by the Acting Executive Director and the Auditor, the discussion focused on the audit schedule and an overview of the process. Questions were answered by the Auditor. Present with the Auditor were the following dignitaries:

- Bennie Medlin, Deputy Director (Acting Executive Director)
- Linda Brooke, Assistant Director
- Ron Lewis, Facility Administrator
- Jesus Reyes, Assistant Facility Administrator
- Shelley Aguirre, Quality Development Supervisor and PREA Coordinator

During the three and one-half days of the on-site audit, the Auditor utilized a private office in the administration area of the facility from which to work and conduct confidential interviews. The Auditor conducted all staff interviews in this office. Resident interviews were conducted in a private office located in the secure assessment wing of the detention facility to facilitate easy movement of residents between programming and interviews. Requested resident and staff files were brought to the Auditor for review in the office. Agency staff provided great assistance in the file review by helping the Auditor find all requested information; this assistance made the file review very efficient and effective, saving the Auditor a lot of time.

Site Review. On the first day of the audit after the entrance conference, the Auditor toured the physical plant escorted by Mr. Ron Lewis, Facility Administrator, Mr. Jesus Reyes, Assistant Facility Administrator and Mrs. Shelley Aguirre, PREA Coordinator. The Auditor toured all secure parts of the facility including the housing areas, the gymnasium, the cafeteria/kitchen, intake area, outside courtyards, classrooms, etc. The Auditor noted internal and external video camera placement throughout the facility and reviewed the main video monitoring setup in the detention intake control room area. Notices of the PREA audit on colored/neon paper were posted throughout the facility as requested by the Auditor.

During the on-site review of the physical plant, the Auditor observed, among other things, the facility configuration, location of cameras, staff supervision of residents, dorm layout including sleeping rooms and shower/toilet areas, placement of posters and PREA informational resources, security monitoring, resident movement procedures, resident programming and resident interaction with staff. The Auditor noted that shower areas in all but one dorm are multiple occupancy and may have four (4) residents showering simultaneously. These showers do not have partitions or walls that allow for resident privacy. One pod that was previously used as a post-adjudication sex offender treatment dorm has a shower area that has a metal partition between the two shower stalls. Staff clarified that any transgender or intersex residents would be allowed to shower separately as would any youth that expressed anxiety or fear of showering with other residents. Because the facility census is low, these accommodations do not pose any issues for supervision. The Auditor took photos of the shower areas for the record and did discuss the shower configuration with the Acting Executive Director. The Auditor recommended that the agency give strong consideration to the shower design in the new building that is in the planning stages currently. Single occupancy showers would be a best practice that would enhance the sexual safety of the residents. The Auditor was provided unimpeded access to all parts of the facility and all secure rooms and storage areas in the facility. The tour concluded after approximately two hours.

Interviews. Formal personal interviews were conducted with facility administration, staff, residents, volunteers and contractors. On the first day of the on-site review, there were 67 residents (i.e., 52 males and 15 females) housed in the facility in the available eight (8) housing units. Only five (5) of the housing units were actually being used (i.e., four in the newer area and one in the oldest part of the facility). During the week of the audit, the census of the facility was higher than in previous weeks causing the facility to have to place a few residents in the older part of the facility. The Auditor interviewed 13 residents representing approximately 20% of the resident population and covering all housing units. Ten (10) of the interviews were random residents and three (3) were specialized residents. Both male and female residents were interviewed (i.e., 10 males, 3 females). Residents were interviewed using the recommended Department of Justice (DOJ) protocols that question their knowledge of a variety of PREA protections generally and specifically their knowledge of reporting mechanisms available to residents to report sexual abuse or harassment. Additionally, the DOJ recommended specialized protocols were used for select specialized residents (e.g., residents reporting prior sexual victimization, LGTBI identified residents, etc.).

Thirty-two (32) total facility staff members were interviewed during the on-site review which included administrative staff, random staff and specialized staff. Interviews included ten (10) random staff representing all shifts in the facility. The shifts for the facility are:

- *Shift 1: 7:00 a.m. to 3:00 p.m.;*
- *Shift 2: 3:00 p.m. to 11:00 p.m.; and*
- *Shift 3: 11:00 p.m. to 7:00 a.m.*

The Auditor interviewed 19 specialty staff including medical (i.e., contract and regular staff), counseling, first responders, investigators, intake and screening, human resources, contract administrator, and volunteer/contractors. Three (3) administrators were interviewed including the agency Executive Director, Facility Administrator, and the PREA Coordinator. Staff was interviewed using the DOJ protocols that question their PREA training and overall knowledge of the agency's zero tolerance policy, reporting mechanisms available to residents and staff, the response protocols when a resident alleges abuse, first responder duties, data collection processes and other pertinent PREA requirements.

The Auditor spoke via telephone to Deborah Caddy, LCSW, Director of the Rape Crisis and Victim Services Program at the Women's Center of Tarrant County, to discuss and confirm the agreement in place with the Center to provide rape crisis intervention services to victims of sexual abuse that occurs in the facility. The Auditor also verified the SANE/SAFE services available through John Peter Smith Hospital by speaking via telephone with Connie Housley, RN, BSN, CA-SANE, SANE Program Coordinator.

File Review. On March 21, 2016, the Auditor requested the facility to provide a listing of personnel and resident files for possible review; upon receipt, the Auditor selected a random sample of files to review and notified the facility. All files were provided to the Auditor in the private office where the Auditor was housed. On Day 3 of the audit, the Auditor reviewed a total of 21 personnel files for staff, volunteers and contractors to determine compliance with training mandates and background check procedures. Six (6) of the files were current employees including an individual who had recently received a promotion. Six (6) of the files were for new employees and were reviewed for compliance with the PREA standards applicable to new hires. Nine (9) files for volunteers and contractors were reviewed. Case files for 19 youth in the facility were reviewed to evaluate screening and intake procedures, resident education and other general programmatic areas. The Auditor reviewed files for all youth interviewed in addition to other select files for specialty residents. Files reviewed represented both male and female youth (i.e., 9 males and 10 females) in the facility.

Closeout. The Auditor conducted an exit conference with the agency officials on the morning of Friday, April 8, 2016. Agency administration and staff were very open and receptive to an honest discussion of areas where PREA compliance needs to be strengthened and the PREA compliance team began corrective measures immediately. Present with the Auditor at the exit conference were:

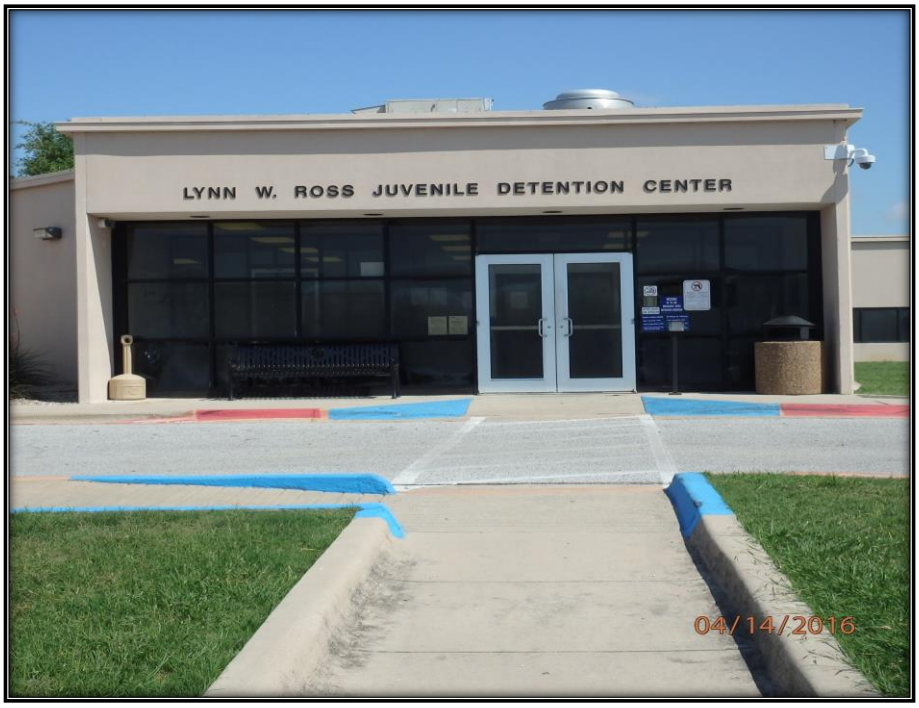
- Bennie Medlin, Deputy Director (Acting Executive Director)
- Linda Brooke, Assistant Director
- Ron Lewis, Facility Administrator
- Jesus Reyes, Assistant Facility Administrator
- Shelley Aguirre, Quality Development Supervisor and PREA Coordinator
- LaChandras Jackson, Operations Manager
- Johnny Dotson, Operations Manager
- Shannon Kelley, Casework Supervisor
- Sheryl Eagleton, Deputy Assistant Director

The corrective actions required by the facility are minimal and the PREA Coordinator began modifying policy and procedures on some issues prior to the audit and during the audit. The Auditor expects the corrective action period to be short as the facility staff is quickly implementing the necessary changes.

DESCRIPTION OF FACILITY CHARACTERISTICS

Tarrant County Juvenile Services (TCJS) operates the Lynn W. Ross Juvenile Detention Center located at 2701 Kimbo Road in Fort Worth, Texas. The facility is located northeast of downtown Fort Worth slightly east of Interstate 35 West. The facility sits upon a 15-acre tract of land owned by the county and has approximately 127,731 square feet.

Tarrant County is among the top three most-populous counties in Texas and approximately the sixteenth most populous county in the nation. As of 2013, Tarrant County had a population of 1.913 million and the projected population for 2015 was 1,982,498.



The Lynn W. Ross Juvenile Detention Center is a 24-hour secure facility for the temporary detention of juveniles who are pending court disposition for alleged law violations or violation of conditions of probation. The detention center is connected to the Scott D. Moore Juvenile Probation Department which also houses the county juvenile district court along with probation services. There are four court rooms with one district court judge and three associate judges in the facility.

According to the 2014 agency annual report, the majority of youth admitted into the detention center were male (72.3%). The average age at detention admission was 15 years. African American youth accounted for 47.4% of youth admitted into detention in 2014, followed by Hispanic (31.2%) and Caucasian youth (20.0%). The most frequent reasons for detaining a youth were that the youth was believed to be a danger to self or others (33.2%) or the youth had been previously found delinquent (32.5%).

The center opened in 1971 with 26 original beds. Fifteen of the beds were dedicated for male offenders and 11 for female. The facility has added 94 beds since it was originally opened. In 1982, a 15-bed wing was added and in 1992

an additional 15-bed wing was added. Both of the wings were constructed similar to the existing wings and share a common living area. In response to increasing referrals, in 2000, an additional 64 beds were constructed giving the facility its current 120 bed capacity. The 64 beds were designed as four pods with 16 beds each. There are three outdoor courtyards on the property that provide a secure outdoor setting with trees and landscaping. The facility has a full-size gymnasium on the property.

Tarrant County is currently in the process of hiring an architect to design a new building for the juvenile courts. In addition to the courts, the 56 beds and classrooms that were built from 1971-1992 will be demolished and replaced with more modern pods and classrooms. At this time, it has not been determined how many new additional beds will be built to replace the 56 beds. The anticipated completion of the project is 2020.

The current facility is well maintained, in good repair and exceptionally clean. Housing units are well equipped and provide residents with a comfortable environment. The older areas of the facility have been recently painted with light colors that enhance the natural lighting in the facility. In walking through all the housing units in the facility as well as the school areas, the Auditor noted that the facility is quiet and order is well maintained in all areas. Staff appears to have good relationships with the youth and the residents appear to follow the direction of staff which contributes to a calm environment conducive to rehabilitation.

The Juvenile Justice Center serves youth age 10-17, both male and female with male residents making up the majority of the population. The average length of stay in the facility is approximately 11 days.

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

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

The Auditor reviewed a copy of the most recent monitoring report of the facility provided by TJJD. The facility scored well on the monitoring visit and no areas of concern were noted by the Auditor as it relates to the PREA standards compliance.

The Juvenile Justice Center has on-site medical services provided by a Registered Nurse and through a contract physician that comes to the facility as needed. The facility has a strong volunteer program that serves residents. Mental health services are provided on-site by a team of counseling professionals. The center provides supervision, activities and individual as well as group counseling that benefit juveniles during their stay. Every juvenile is screened for identification of emotional and mental health concerns. Basic health care screening is also provided through an on-site medical clinic. All juveniles admitted to detention receive educational, medical, mental health, recreational and life skills training. All youth receive a thorough orientation to the detention center rules and regulations and information regarding PREA. All youth receive academic programming provided through the Fort Worth Independent School District, including special educational services. School records are forwarded to the school where the youth will be attending once he/she is released from the detention center. Every juvenile has the opportunity to visit with immediate family members for 30 minutes a day and may have a daily five-minute telephone call with a parent or legal guardian.

SUMMARY OF AUDIT FINDINGS

During the past 12 months, the Lynn W. Ross Juvenile Detention Center reported zero allegations of sexual abuse occurring in the facility in their responses to the *PAQ*. No criminal or administrative investigations were conducted in the past 12 months.

The agency has a strong zero tolerance policy in place and comprehensive PREA policies covering all the requirements of the PREA standards. Overall, the interviews with residents reflected that they are aware of and understand the PREA protections and the agency's zero tolerance policy. Residents receive written materials at intake (e.g., Resident Orientation Form, etc.) that provide detailed information about PREA protections, the multiple ways to report sexual abuse or harassment and ways to protect themselves from abuse. After intake, residents are provided more comprehensive education on PREA that includes personal instruction in addition to watching a comprehensive PREA educational video. Posters regarding reporting sexual abuse and sexual harassment are placed in housing units, cafeteria, classrooms and common areas. Residents indicated they understand the various ways to report abuse. Residents could articulate to the Auditor what they would do and who they would tell if they were sexually abused. Residents expressed to the Auditor that they trust staff and would report to staff in the facility. The Auditor's observation of staff interaction with residents was positive and appropriate. Residents consistently indicated to the Auditor that they felt safe in the facility which is a significant indicator of a positive and sexually safe institutional culture.

All facility staff interviewed indicated they had received detailed PREA training over a period of months. They could consistently articulate the meaning of the agency's zero tolerance policy. Staff was knowledgeable about their roles and responsibilities in the prevention, reporting and response to sexual abuse and sexual harassment. Staff articulated the variety of reporting mechanisms available for residents and staff to use to report sexual abuse or sexual harassment. Staff demonstrated they were well trained on the PREA first responder's protocol for any PREA related allegation and they could clearly articulate the appropriate steps they would follow if they were the first responder to an incident. However, because sexual abuse incidents at the facility are rare, it will be important going forward to provide periodic training reinforcement and practice on the protocol through training events or mock drills to maintain the skill set of the first responders. Staff consistently appeared to be fully engaged with the residents. They display a genuine sense of caring for the kids and for ensuring sexual safety in the facility. The agency has done a great job with the education of staff by providing recurring training on PREA that reinforces the knowledge of the staff members. General PREA training and training on specialized topics are provided to staff and this commitment to excellence in education is apparent in staff's preparedness for the audit.

In summary, after reviewing all pertinent information and after conducting the on-site review, resident interviews and staff interviews, the Auditor found the facility has a positive, sexually safe environment and culture. Agency leadership and staff have clearly made PREA compliance a high priority and have devoted a significant amount of time and resources to policy development, training of staff and education of residents on all the key aspects of PREA. The Auditor reviewed the PREA training material/curriculum and noted that the agency team has done an excellent job of making training a high priority in the facility. The outstanding level of pre-audit preparations and organization of all documents submitted to the Auditor was evident. Facility staff was incredibly helpful and supportive to the Auditor during the audit. During file review, staff members assisted the Auditor by pulling all necessary information from the files of residents and staff for the Auditor to review, as well as making the full file available. This saved the Auditor a lot of time during the on-site portion.

The agency has a strong PREA policy that forms the foundation for their compliance efforts. Discussions with agency leadership and facility management reinforced the agency's commitment to ensuring the sexual safety of residents and staff in the facility. The agency is in a period of transition as their long-tenured Chief Juvenile Probation Officer/Executive Director recently retired and the replacement has not yet been hired. Despite this fact, the current facility leadership and staff were fully engaged and prepared for the audit and demonstrated commitment to PREA and sexual safety for their facility. It was further evident that staff and residents were invested in PREA as demonstrated through their knowledge and understanding of the protections and requirements. The positive culture of sexual safety in this facility is evident in the overall operations of this facility and the level of PREA compliance noted by this Auditor. While there are certain areas of compliance that will require strengthening through corrective actions as detailed in this report, those corrections are relatively easy to accomplish and the Auditor expects full compliance will be achieved very soon. The Auditor worked with the PREA Coordinator prior to the on-site audit to begin corrective actions on a few standards that required minor adjustments. The Auditor noted the overwhelmingly positive attitude from agency administration and PREA compliance team members toward Auditor input on the program and any suggestions for

improvement. Recommendations from the Auditor were taken with gratitude and a sincere willingness to improve PREA compliance strength which ultimately will provide the highest level of protection of the sexual safety of residents.

The final status of standards that were exceeded, met, not met or not applicable is detailed below. There are a total of 41 standards. Most standards have between 1-10 subsections. To achieve compliance on any given standard, the facility must achieve 100% compliance with each and every subsection within the standard. The compliance performance for this Interim Audit Report is shown below.

PREA Standards Compliance Overview – Interim Audit Report

Number of standards exceeded: 2

- §115.317; and
- §115.342.

Number of standards met: 30

- §115.311; §115.316; §115.318;
- §115.321; §115.322;
- §115.331; §115.332; §115.333; §115.334; §115.335;
- §115.351; §115.354;
- §115.361; §115.362; §115.363; §115.364; §115.365; §115.367; §115.368;
- §115.371; §115.372; §115.373; §115.376; §115.377; §115.378; and
- §115.381; §115.382; §115.383; §115.386; §115.388.

Number of standards not met: 8

- §115.312; §115.313; §115.315
- §115.341;
- §115.352; §115.353; and
- §115.387; §115.389.

Number of standards not applicable: 1

- §115.366.

Total Standards: 41

OCTOBER 2016 UPDATE SINCE THE AUDIT: CORRECTIVE ACTIONS TAKEN TO ACHIEVE FULL COMPLIANCE

Since the on-site portion of this audit, Tarrant County Juvenile Services has a new Director, Mr. Bennie Medlin. Mr. Medlin was selected by the juvenile board as the new Director of Juvenile Services and he officially took office on July 23, 2016.

The Interim Audit Report reflected that there were eight (8) standards that were in non-compliance at the Lynn W. Ross Juvenile Detention Center. Therefore, a required corrective action period not to exceed 180 days began on May 6, 2016 and could extend no longer than November 1, 2016. The Auditor recommended corrective actions for the facility and administration agreed; immediate corrections began for those standards found to be in non-compliance. The facility completed the required corrective actions requested by the Auditor to bring the facility into full compliance with the PREA standards. Initial documentation of the corrective action was received by the Auditor beginning in August 2016 and continuing through late October 2016. The Auditor received documentary evidence via email and corresponded with agency administration via telephone conferences and email throughout the corrective action period to clarify any questions or concerns.

The Auditor reviewed the submitted documentation to determine if full compliance was achieved. In some cases, the Auditor requested clarifications and/or supplemental documentation via emails and phone calls with facility staff. The agency complied with all requests from the Auditor. A summary of the evidentiary basis for determining full compliance is discussed within each standard that was originally noncompliant. As a result of successful corrective action, the Auditor determined that the Lynn W. Ross Juvenile Detention Center has achieved full compliance with all PREA standards as of the date of this final report. The summary of compliance based upon this final report is found below.

PREA Standards Compliance Overview – Final Audit Report

Number of standards exceeded: 2

- §115.317; and
- §115.342.

Number of standards met: 38

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

Number of standards not met: 0

Number of standards not applicable: 1

- §115.366.

Total Standards: 41

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. Tarrant County Juvenile Services (TCJS) Completed *Pre-Audit Questionnaire (PAQ)* for the Lynn W. Ross Juvenile Detention Center and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:
    a. *115.311 Zero Tolerance (Page 3 of 21)*
4. *Agency Organizational Chart*
5. Interviews with the following:
    a. PREA Coordinator

Findings (By Subsection):

Subsection (a): TCJS has a comprehensive policy on sexual abuse and sexual harassment contained in their Policy 115.311. The policy clearly mandates zero tolerance toward all forms of sexual abuse and sexual harassment. The policy is detailed and well written. The policy outlines the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment.

Subsection (b): The agency has designated Shelley Alexander Aguirre as the PREA Coordinator. Her title is Quality Development Supervisor. She reports directly to the Deputy Assistant Director for Quality Development, Sheryl Eagleton. Ms. Eagleton reports to the agency Assistant Director, Ms. Linda Brooke who reports directly to the Agency Executive Director. The agency is currently doing a national search for a new Executive Director and that individual is expected to be hired in the summer of 2016. Mrs. Aguirre states that she has sufficient time and authority to develop, implement, and oversee the agency's efforts to comply with PREA. The Auditor found her to be well organized, deliberate and detail oriented which has served the agency well with establishment of a strong PREA program in the facility.

Subsection (c): Tarrant County operates only one facility; therefore, they are not required to have a PREA Compliance Manager.

Corrective Action: None.

Standard 115.312 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. Proposed new language for all residential contracts that requires PREA compliance
4. Interviews with the following:
    a. Agency's Contract Administrator

Findings (By Subsection):

Subsection (a): Tarrant County utilizes residential placements for select juveniles ordered by the courts to be placed outside of the home. Currently, their contracts are not compliant with this standard. The Auditor interviewed the agency contract administrator who has been working diligently to bring the agency into compliance with this section over the past months. The agency has developed language for their new contracts that will require PREA compliance as required by this standard. Tarrant County is in the process of sending out RFP's for all residential contracts and they will be approved no later than October 1, 2016. The contracts will all contain the mandatory PREA clause requiring compliance. The Auditor was provided with the language that will be in all new contracts and it is compliant with this standard.

Subsection (b): Tarrant County is in the process of sending out RFP's for all residential contracts at this time and they will be approved no later than October 1, 2016. The contracts will all contain the mandatory PREA clause requiring compliance.

Corrective Action: The following corrective actions are required to demonstrate compliance with this standard. All changes or modifications to policy and/or practice must be institutionalized through training of all relevant staff and demonstration of consistent application of the required policy/practice for a period of time. Documentation of the training and evidence of facility implementation of the new policy/practice must be submitted to the Auditor in writing.

1. TCJS should complete its RFP process for all new residential contracts. Contracts should be monitored by the agency to determine the PREA compliance status of all vendors (i.e., whether vendor is PREA compliant via a final audit report or whether the vendor is in the process of having an audit, etc.).

2. TCJS should enhance its PREA policy by including the requirement for residential contracts to have language requiring PREA compliance.

Verification of Corrective Action since the Audit

The Auditor was provided supplemental documentation to evidence and demonstrate the required corrective actions that were taken by the administration regarding this standard. This documentation is discussed below.

Additional Documentation Reviewed:

1. TCJS Policy:
    a. *Institutional Services Section, PREA (Pages 5)* Revised Policy Executed 9-21-16

2. *Tarrant County Juvenile Services Status of Residential Contract Providers in Becoming PREA Certified*
3. *Executed Residential Services Contract (September 1, 2016 to September 1, 2017) for Clarinda Academy*

As of the date of this report, the agency has executed new contracts with all residential service providers and each contract now has the explicit language that requires PREA compliance, including data collection. The agency provided an update on the PREA compliance status of all their contract providers; all 11 vendors have had their PREA audits and three are still in the corrective action phase. The facility is now fully compliant with this standard.

Standard 115.313 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:
    a. *Institutional Services Section, PREA (Pages 5-6 of 21)*
4. *Staffing Plan* development overview document with meeting dates, etc.
5. *Lynn W. Ross Juvenile Detention Center Staffing Plan (Executed 2-12-16)*
6. *TCJS Staffing Plan Deviation Form*
7. Documentation of training on staffing plan
8. *PREA Documentation of Unannounced Rounds* form
9. Interviews with the following:
    a. Facility Administrator
    b. PREA Compliance Manager
    c. Intermediate or Higher-Level Facility Staff
10. Observations of supervision ratios during physical plant on-site review in housing and program areas

Findings (By Subsection):

Subsection (a): TCJS has developed a staffing plan that provides for adequate levels of staffing and video monitoring to protect residents against abuse. The written plan was developed during September 2015 through January 2016 and was executed by the agency on February 12, 2016. The staffing plan states that in calculating adequate staffing levels and determining the need for video monitoring, the agency will consider the 11 elements detailed in this subsection. However, the staffing plan contains no narrative explaining the agency's findings on the 11 elements or any explanatory comments about the 11 elements. The plan should be enhanced by providing at least minimal findings or conclusions in a narrative form on each element. Further, the plan could be enhanced by including facility schematics that show post assignments/staff placements, movements, etc., and other key information. The agency provided documentation evidencing that training of staff on the staffing plan has occurred.

Subsection (b): Texas state law requires juvenile facilities to meet a 1:12/1:24 staffing ratio currently. Agency policy requires adherence to these mandatory state ratios. The agency reports in their response to the *PAQ* that there have been no deviations from the staffing plan ratios in the past 12 months. Interviews with the Facility Administrator corroborate the compliance with staffing ratios. The agency frequently exceeds the minimum ratios required by state law (i.e., regulations in 37 Texas Administrative Code set by the Texas Juvenile Justice Department) and meets the new PREA ratios that will become effective in October of 2017. The agency has a form that would be used in the event of a deviation to document the reasons for the deviation from the staffing plan. During the on-site review of housing and program areas, the Auditor observed that the ratios were in compliance and exceeded in most cases.

Subsection (c): This subsection regarding the new juvenile staffing ratios is not applicable until October 1, 2017.

Subsection (d): The staffing plan was formally put into place in February of 2016; however, the agency by law had to meet minimum ratios even prior to a formalized staffing plan document. Page 13 of the staffing plan requires an annual assessment to occur and this will occur in 2017. Interviews with the PREA Coordinator and Facility Administrator indicate the annual review will occur in 2017. The language of the staffing plan could be strengthened if the annual review language tracked the language of the PREA standard Subsection (d) closer. The Auditor recommends this enhancement.

Subsection (e): The facility's staffing plan requires intermediate-level or higher-level staff to conduct unannounced rounds in the facility once a month on each shift. The staff designated is the Deputy Assistant Director, Assistant Facility Administrator and/or the Operations Manager. These individuals must conduct the rounds at a time that they are normally not on duty. Documentation is required in the *PREA Unannounced Rounds Log* as well as the *PREA Unannounced Rounds Documentation* form. The policy prohibits staff from alerting other staff that the supervisory rounds are occurring. In interviews with the facility administration that conduct the rounds, it was clear that supervisors were monitoring whether staff were alerting other staff by picking up a radio upon entering the building and listening to radio transmissions between staff during the unannounced rounds. The facility submitted completed *PREA Unannounced Rounds Documentation* forms to demonstrate compliance. The Auditor reviewed the rounds and noted several negative patterns and issues that needed to be addressed. Not all shifts were covered by the rounds during the months reviewed (i.e., December 2015, January 2016, and February 2016). One administrator had a very noticeable pattern of doing early morning rounds on Shift 3 during each of these months. Rounds appeared to be heavily weighted on Thursdays as well. The Auditor shared this information with the facility on March 4, 2016 prior to the on-site audit phase and the facility began corrections on this.

Corrective Action: The following corrective actions are required to demonstrate compliance with this standard. All changes or modifications to policy and/or practice must be institutionalized through training of all relevant staff and demonstration of consistent application of the required policy/practice for a period of time. Documentation of the training and evidence of facility implementation of the new policy/practice must be submitted to the Auditor in writing.

1. The agency should enhance its staffing plan to include narrative findings on each of the 11 elements detailed in Subsection (a) of this standard. Additionally, the plan should be enhanced to include facility schematics that demonstrate staff placement/post assignments, camera locations and other key information. The Auditor has referred the agency to the PREA Resource Center archived webinar and white paper on developing compliant staffing plans.

2. The agency should ensure that the unannounced rounds are conducted on all shifts at least monthly. Training must be conducted with all individuals that will conduct the rounds to ensure there is an understanding of how to conduct the rounds with no discernable patterns that staff may pick up upon. Documentation of the conducting of these rounds must be submitted to the Auditor during the corrective action period.

Verification of Corrective Action since the Audit

The Auditor was provided supplemental documentation to evidence and demonstrate the required corrective actions that were taken by the administration regarding this standard. This documentation is discussed below.

Additional Documentation Reviewed:

1. *Lynn W. Ross Juvenile Detention Center Staffing Plan (Newly Revised Plan Executed 9-9-16)*
2. *Security Plan (Facility Schematic)*
3. *Security Plan Sectors A, B, C, D, E and F (Schematics showing camera placements, etc.)*
4. Unannounced Rounds Documentation May-October 2016
5. PREA Update Training Agenda October 19, 2016
6. PREA Update Training Agenda Sign-in Sheet October 19, 2016 (Training of all operations managers)

The agency revised its staffing plan to provide a more robust plan that fully addresses the elements in this standard. Also included are facility schematics that help bring greater detail to the plan overall. The facility conducted training on the new staffing plan with all operations managers who in turn will train their staff. A copy of the new staffing plan was posted to the agency Share Point site so that all staff could have access.

Documentation for unannounced rounds for the time period May-August 2016 was submitted and the Auditor reviewed these rounds. The Auditor requested the unannounced rounds for September and October as well to review. After review of the rounds, the Auditor found no negative patterns and the agency has corrected the prior issue with these rounds. The Auditor suggested and the facility agreed that monitoring the rounds for patterns would be a good practice ongoing. The Auditor provided a sample spreadsheet that the facility could use for this purpose. Additionally, the facility provided training on the procedure for unannounced rounds with select facility staff that will be conducting these rounds. The facility is now fully compliant with this standard.

Standard 115.315 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:
    a. *Institutional Services Section, PREA (Pages 6-8 of 21)*
4. Interviews with the following:
    a. Random Residents
    b. Random Staff
5. Training Documentation:
    a. PREA PowerPoint Training Presentation

b. *TCJS Training Verification Form*
c. *Training Sign-In Sheets (December 3, 10, and 31, 2015)*
d. *PREA Training links to PREA Resource Center resources (The Moss Group, Inc. video training on conducting cross-gender pat-down searches)*

6. Observation of announcement being made by the Facility Administrator in facility housing units during tour of physical plant

Findings (By Subsection):

Subsection (a): TCJS policy prohibits cross-gender strip or pat searches except in exigent circumstances or when performed by a medical practitioner. Policy further requires any anal or genital body cavity search must be conducted by a licensed physician. The policy does not explicitly mention visual body cavity searches, but in conversations with the PREA Coordinator, it was stated that visual body cavity searches are considered within the term "body cavity" searches. It is recommended that the policy be amended to explicitly make this clear so that the policy is strengthened. The facility reports in the *PAQ* that in the past 12 months, there have been no cross-gender strip or cross-gender visual body cavity searches of residents.

Subsection (b): TCJS policy prohibits cross-gender pat-down searches except in exigent circumstances. The facility reports in the *PAQ* that in the past 12 months, there have been no cross-gender pat-down searches of residents. Interviews with random staff and random residents confirmed that the facility does not do cross-gender pat searches of residents.

Subsection (c): TCJS reports there have been no cross-gender strip searches, cross-gender visual body cavity searches and cross-gender pat-down searches. Therefore, the Auditor had no documentation to review. The TCJS policy does not require documentation and justification of all searches and the Auditor recommends that the policy be strengthened to include this requirement.

Subsection (d): TCJS policy provides that all residents must be able to shower, perform bodily functions and change clothing without the viewing of opposite gender staff. Interviews with staff and residents confirm that cross-gender viewing is not occurring during these times. Policy requires staff of the opposite gender to announce their presence when entering an area where residents are likely to be doing the above activities. Interviews with residents and staff indicate staff is complying with the announcement requirement. During the tour, the Auditor observed the Facility Administrator consistently making the required announcement as the group entered the housing units.

Subsection (e): TCJS has a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. The Auditor interviewed staff that corroborated this policy is the practice of the facility. There were no transgender or intersex residents in the facility during the on-site portion of the audit.

Subsection (f): TCJS policy requires facility staff to be trained to conduct cross-gender pat-down searches, and searches of transgender and intersex youth in a professional and respectful manner and in the least intrusive manner possible consistent with security needs. The agency has trained staff on how to conduct these searches; 88% of the facility's full-time staff has been trained according to the facility's responses to the *PAQ*. The training documentation and curriculum used was submitted to the Auditor for review and the Auditor found it to be comprehensive and appropriate training. Interviews with staff indicate that they had received this training and staff demonstrated and articulated a clear understanding of how to conduct these searches. However, the staff was not clear on whether intersex and transgender youth could request a cross-gender search if they felt more comfortable with that based on their gender identity. The agency has not trained staff on the exception to the prohibition on cross-gender pat searches for transgender and intersex residents who express a preference for a cross-gender search. Interviews with staff indicate they are confused on this exception and need additional training and clarification on this exception.

Corrective Action: The following corrective actions are required to demonstrate compliance with this standard. All changes or modifications to policy and/or practice must be institutionalized through training of all relevant staff and demonstration of consistent application of the required policy/practice for a period of time. Documentation of the training and evidence of facility implementation of the new policy/practice must be submitted to the Auditor in writing.

1. TCJS needs to provide additional training to all staff regarding the exception to the prohibition on cross-gender pat searches for transgender and intersex residents who express a preference and request a cross-gender search. While staff has been trained on conducting searches of transgender and intersex residents with professionalism and in a respectful manner, the staff is still unclear on how the exception works in practice. Documentation of this training must be provided to the Auditor to demonstrate compliance

Verification of Corrective Action since the Audit

The Auditor was provided supplemental documentation to evidence and demonstrate the required corrective actions that were taken by the administration regarding this standard. This documentation is discussed below.

Additional Documentation Reviewed:

1. Training Email to staff Dated October 11, 2016
2. PREA Update Training Agenda October 19, 2016
3. PREA Update Training Agenda Sign-in Sheet October 19, 2016 (Training of all operations managers)

The facility provided additional training to staff regarding the exception to the prohibition on cross-gender pat searches for transgender and intersex residents. The agency reinforced the prior training through two separate provisions of additional information. All staff were provided information through a training email in early October. Additionally, the agency provided training on this specific subject to all detention operations managers who will reinforce this with their teams. The facility is now fully compliant with this standard.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:
    a. *Institutional Services Section, PREA (Pages 9-10 of 21)*
4. Interviews with the following:
    a. Agency Head

b. Random Staff

5. Translation Contracts with:
    a. Hired Hands, Inc. (sign language);
    b. Language Consultants, Inc. (all except Spanish); and
    c. Universe Technical Translation (Spanish)
6. Resident Education:
    a. *Safeguarding Your Sexual Safety* Video (English and Spanish Versions)
7. Staff Education:
    a. Documentation of staff training on the requirements of this standard held on June 11, 18, and 25, 2015
8. On-Site Review observation of PREA posters located throughout the facility and in the housing areas

Findings (By Subsection):

Subsection (a): The agency has established procedures to provide disabled residents equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The agency has several bilingual staff (Spanish speaking) that can be utilized if translation services are needed for a resident. Additionally, the agency has three contracts (cited above) with organizations that provide sign-language and translation services to the facility when needed.

Subsection (b): The agency has established procedures to provide limited English proficient residents with equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. In addition to the translation services, the agency provides a comprehensive PREA training video in both English and Spanish. PREA posters throughout the facility are in both English and Spanish.

Subsection (c): TCJS policy states that the facility shall not rely on resident interpreters except in exigent circumstances. The facility reports in the *PAQ* that during the past 12 months, there have been no cases where a resident interpreter was utilized. Interviews with staff indicate that they do not use resident interpreters in compliance with their policy. Staff could articulate to the Auditor why using a resident interpreter is not a good practice.

Corrective Action: None.

Standard 115.317 Hiring and promotion decisions

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided

3. TCJS Policy:
    a. *Institutional Services Section, PREA (Pages 4-5 of 21)*
4. *TCJS Acknowledgement and Ongoing Duty to Disclose PREA Employment Standards Violation* Form
5. Pre-employment questions for new applicants (Neogov)
6. Interviews with the following:
    a. Administrative (Human Resources) Staff
7. Personnel files for current employees, new employees and employees receiving promotions

Findings (By Subsection):

Subsection (a): TCJS policy prohibits hiring or promoting anyone who may have contact with residents, or enlisting the services of a contractor who may have contact with residents if these individuals have engaged in any of the specified conduct in this subsection. A review of personnel files corroborated that the agency asks the required questions about past conduct of potential new employees and those current employees being considered for promotion. Criminal background checks were found in all files reviewed. The Auditor reviewed a file for a new contractor and determined all required checks were completed.

Subsection (b): TCJS policy requires the agency to consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor who may have contact with the residents. The Auditor interviewed a human resources staff member who corroborated that this is the practice. The Auditor reviewed files for new hires, promotions, and contractors and found all required checks being completed.

Subsection (c): The agency policy requires that prior to hiring new employees who may have contact with residents, the agency must conduct a criminal background records check and a child abuse registry check. Additionally, the policy requires the agency to make best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. The Auditor interviewed a human resources administrator who confirmed this is the practice of the agency; however, the Auditor found no files where the institutional reference checks were required and thus documented. The Auditor provided the facility with sample forms that they can use to document these reference checks when those are required. In the *PAQ*, the agency reports that in the past 12 months, they have hired six new staff that has contact with residents. The Auditor reviewed the six files for these new hires and determined the required checks were completed as required by this standard.

Subsection (d): The agency policy requires that, prior to enlisting the services of a contractor who may have contact with residents, the agency must conduct a criminal background records check and a child abuse registry check. The Auditor reviewed several files for contractors and determined the required checks are being done.

Subsection (e): The agency policy states that background checks will be conducted at least every five years on employees, contractors, interns and volunteers. This exceeds the standard which only requires this of employees and contractors. Additionally, the agency must do the criminal background check every two years for employees that are certified probation and supervision officers through the Texas Juvenile Justice Department (TJJD). A review of the files corroborated this practice. The agency practice exceeds the requirements this standard.

Subsection (f): The agency policy states that all applicants and employees who may have contact with residents directly shall be asked about previous misconduct described in this standard in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The agency utilizes the above cited form to ask the required questions; additionally, in the application process the applicant must answer a series of questions of which PREA related questions are included. Interviews with human resources staff and file reviews corroborate this is the practice.

Subsection (g): Agency policy states that material omissions regarding the conduct described in this section, or the provision of materially false information, shall be grounds for termination.

Subsection (h): Agency policy states that unless prohibited by law, the facility shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an employer for whom such employee has applied to work. Interviews with human resources staff corroborate this is the practice. The Auditor provided the facility with sample forms that can be used to document the provision of information about a former employee upon request by an institutional employer.

Corrective Action: None.

Standard 115.318 Upgrades to facilities and technologies

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

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. Interviews with the following:
    a. Agency Head
    b. Facility Administrator
4. On-site review of physical plant

Findings (By Subsection):

Subsection (a): This subsection is not applicable. The agency has not acquired a new facility or made substantial expansions or modifications of the existing facility since August 20, 2012.

Subsection (b): In 2014, the facility installed a new camera system called DV-Tel Latitude 6 Surveillance System. It was installed by vendor, Entech and there were 95 additional cameras installed to supplement the existing video system. The system has client application for monitoring and reviewing video and alarms. The system has no audio and a 45-day archive-retention period. The system allows users to view up to sixteen live and archived video sources per monitor, with multiple monitors supported on each workstation. The video coverage in the housing units provides 360 degree views of the housing area from the ceiling cameras; the cameras utilize blur dots in the resident rooms to ensure privacy. Other major features of this system include:

- Sequences and guard tours.
- Capability to record sequences.
- PTZ Control and Digital Zoom
- Multiple –source bookmarking. Bookmarks are enhanced by incidents, a powerful new feature that allows users to associate multiple media sources to a single occurrence simply by highlighting multiple tiles prior to clicking the book mark button.
- Full alarm management capabilities.

- Instant replays with alternative content arming.
- Interactive map on the main workstation (front console). It allows users to access cameras simply by clicking on the specific camera on the camera map displayed on the monitor.

The county Information Technology Department maintains this system. In interviews with the Agency Head and the Facility Administrator, it was confirmed that the agency considered how acquisition of additional cameras would enhance the agency's ability to protect residents from sexual abuse and this was a primary focus of acquiring the new equipment.

Corrective Action: None.

Standard 115.321 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:
    a. *Institutional Services Section, PREA (Pages 12, 16-17 of 21)*
4. Interviews with the following:
    a. Random Staff
    b. PREA Coordinator
    c. Deborah Caddy, LCSW, Director of the Rape Crisis and Victim Services Program at the Women's Center of Tarrant County
    d. Connie Housley, RN, BSN, CA-SANE, SANE Program Coordinator at the John Peter Smith Health Network
5. Email correspondence between Ron Lewis and Chief Deputy Mike Simonds with the Tarrant County Sheriff's Office regarding Standard 115.321
6. Memorandum from Chief Deputy Mike Simonds with the Tarrant County Sheriff's Office to Ron Lewis
7. Email correspondence between PREA Coordinator and SANE Program Coordinator at John Peter Smith Health Network
8. Draft *Memorandum of Understanding* between TCJS and John Peter Smith Hospital
9. Executed *Memorandum of Understanding* between TCJS and Women's Center of Tarrant County
10. Women's Center of Tarrant County Website: http://womenscentertc.org/

Findings (By Subsection):

Subsection (a): TCJS conducts administrative investigations related to sexual abuse and sexual harassment. All criminal investigations are conducted by the Tarrant County Sheriff's Office. The facility follows a uniform evidence protocol via their first responder's protocol that maximizes the potential for obtaining usable physical evidence for

administrative and criminal prosecutions and it is based on the national protocol cited in this standard. It is recommended that the facility explicitly name the national protocol on which their procedures are based (i.e., the U.S. Department of Justice's Office on Violence against Women publication*, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents*,". Interviews with staff corroborate their understanding of the evidence collection protocol and confirm this is the practice of the facility. All forensic evidence gathering is conducted by the Tarrant County's Sheriff's Office crime scene unit. The crime scene unit follows the protocol from the International Association for Identification (IAI).

Subsection (b): The facility follows a uniform evidence protocol via their first responder's protocol that maximizes the potential for obtaining usable physical evidence for administrative and criminal prosecutions and it is based on the national protocol cited in this standard. It is recommended that the facility explicitly name the national protocol on which their procedures are based (i.e., the U.S. Department of Justice's Office on Violence against Women publication, *"A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents*,".

Subsection (c): The agency reports that in the past 12 months, there have been no allegations of sexual abuse; thus, there have been no SANE/SAFE forensic exams performed. TCJS policy states that all residents who experience sexual abuse shall have access to a forensic medical examination without financial cost through John Peter Smith Hospital (JPSH) by a SANE Nurse. The agency has a draft MOU with JPSH to provide these services. The MOU is in process and the Auditor will need to see the executed agreement once finalized. The Auditor spoke via telephone with Connie Housley, the SANE Program Coordinator at JPSH and confirmed SANE services would be provided to resident victims.

Subsection (d): TCJS has entered into a *Memorandum of Understanding* with the Women's Center of Tarrant County to provide rape crisis and victim advocacy services to resident victims. This MOU was executed in February 2016. The Auditor spoke via telephone with Deborah Caddy, the Director of the Rape Crisis and Victim Services Program at the Women's Center, who confirmed the provision of services to residents at the facility that are victims of sexual assault.

Subsection (e): TCJS has entered into a *Memorandum of Understanding* with the Women's Center of Tarrant County to provide rape crisis and victim advocacy services to resident victims. In the event of an incident, TCJS would call the Women's Center who would provide an advocate to be with the victim for the SANE exam at JPSH. Interviews with the PREA Coordinator confirm this would be the practice in the event of a sexual assault.

Subsection (f): All criminal investigations are conducted by the Tarrant County Sheriff's Office. TCJS requested that the office follow the requirements of Standard 115.321 (a) through (e). The Sheriff's Office responded with a *Memorandum* dated February 18, 2016 detailing the protocol utilized by the office. The protocol is from the International Association for Identification (IAI), whose website states they are the oldest and largest forensic association in the world. This professional forensic association represents a diverse, knowledgeable and experienced membership that are assembled to educate, share, critique and publish methods, techniques and research in the physical forensic science disciplines. The IAI is dedicated to the continual advancement of forensic science and innovation utilizing the latest technical developments in conjunction with the principles of forensic science. The Auditor finds this compliant.

Corrective Action: None.

Standard 115.322 Policies to ensure referrals of allegations for investigations

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

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:
    a. *Institutional Services Section, PREA (Pages 12, 14 and 19 of 21)*
4. Interviews with the following:
    a. Agency Head
    b. Investigative Staff
5. Agency website: http://access.tarrantcounty.com/en/juvenile-services/division-listing/detention/detention-visitation-schedule/PREA.html

Findings (By Subsection):

Subsection (a): The agency reports in the *PAQ* that in the past 12 months there have been no allegations of sexual abuse or sexual harassment that were received; therefore, there have been no administrative or criminal investigations conducted. TCJS policy states that all allegations of sexual abuse/sexual harassment and staff neglect or violation of responsibilities that may have contributed to such incidents will be investigated either criminally or administratively or both. Policy further states that upon receiving any allegation of sexual abuse or sexual harassment, the facility administrator or designee shall report the allegation to the Tarrant County Sheriff's Office and Texas Juvenile Justice Department (TJJD). The Sheriff's Office will conduct the criminal investigation and TJJD conducts an external administrative investigation. The Auditor interviewed the Agency Head and confirmed this practice.

Subsection (b): The agency has a mandatory reporting policy that requires all allegations of sexual abuse, sexual harassment, and staff neglect be referred for investigation to law enforcement (i.e., Tarrant County Sheriff's Office), to the state agency with oversight of the facility (i.e., TJJD), and to internal agency investigators via the PREA Coordinator. The policy is posted on the agency website as verified by the Auditor. Additionally, the agency has a policy governing internal administrative investigations. Interviews with investigative staff corroborate that this is the practice of the facility.

Subsection (c): The agency refers all allegations that may be criminal to the Tarrant County Sheriff's Office; additionally, all allegations of abuse, neglect, sexual abuse, and sexual harassment must be referred to the Texas Juvenile Justice Department for investigation per Title 37 Texas Administrative Code. The agency website explains the responsibilities of the Sheriff's office to conduct the criminal investigations.

Corrective Action: None.

Standard 115.331 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:
    a. *Institutional Services Section, PREA (Pages 6-7 of 21)*
4. Interviews with the following:
    a. Random Staff
    b. PREA Coordinator
5. Employee training records (training sign in sheets and records, employee signature pages)
6. *TCJS Training Verification Form*
7. Training curriculum (PowerPoint Slides, links to external trainings utilized)

Findings (By Subsection):

Subsection (a): The agency reports in the *PAQ* that they have trained 238 staff that have contact with residents on PREA. TCJS trains all employees who may have contact with residents on the 11 items detailed in this standard. PREA trainings were conducted beginning in June 2015 on multiple dates. Trainings continued on multiple dates in October of 2015. Refresher and specialized trainings were conducted in December 2015 and January, February and March of 2016. The Auditor reviewed training curriculum and employee training records to confirm this practice. Interviews with random staff corroborate that they have received general PREA training and refresher and/or specialized PREA training.

Subsection (b): The agency policy requires that training provided be tailored to the unique needs and attributes and gender of the residents at the facility through gender specific training along with adolescent development training. The Auditor reviewed training curriculum and employee training records to confirm this practice and discussed the training provided with the PREA Coordinator.

Subsection (c): Agency policy requires refresher training be conducted every two years and in years when refresher training is not provided, refresher information will be provided to employees. The PREA Coordinator indicated this policy is being put into practice currently since two years have not yet elapsed since the original PREA training began.

Subsection (d): The agency requires all employees to sign the training sign-in sheet for all trainings. Additionally, each employee signs the *Training Verification Form* evidencing their completion of the training. Training files for a sample of employees were reviewed by the Auditor to corroborate that employees have received the training and signed these forms. It is recommended that the *Verification Form* have additional language included that explicitly states that the employee understands the training; while the Auditor was convinced that employees are receiving the required training and understanding the material, this additional language will strengthen PREA compliance.

Corrective Action: None.

Standard 115.332 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:
    a. *Institutional Services Section, PREA (Pages 6-7 of 21)*
4. Interviews with the following:
    a. Volunteers
    b. Contractors
    c. PREA Coordinator
5. Volunteer and Contractor training records (training sign in sheets and records, signature pages)
6. *TCJS Training Verification Form*
7. Training curriculum (PowerPoint Slides, links to external trainings utilized)

Findings (By Subsection):

Subsection (a): Agency policy requires volunteers and contractors that have contact with residents to be provided the training required by the PREA standards. TCJS reports in the *PAQ* that 42 volunteers and contractors have received the mandatory training to date. Multiple training dates were held on January 13th, 19th, 22nd, and 24th of 2016 and also in March of 2016. Twelve additional individuals were trained in March 2016 and the Auditor was provided this supplemental documentation. The training curriculum used for volunteers and contractors was reviewed by the Auditor and meets the required objectives. Interviews with volunteers and contractors confirmed they had received PREA training and were knowledgeable in their responsibilities regarding PREA. The Auditor reviewed training files for select contractors and volunteers and confirmed they had received the training required.

Subsection (b): The training provided to volunteers and contractors is a slightly smaller version of the training all employees receive. The training covers the required material necessary to ensure volunteers and contractors are knowledgeable on their PREA duties and responsibilities.

Subsection (c): The agency maintains documentation confirming that volunteers/contractors understand the training they have received. The Auditor reviewed several volunteer and contractor files to corroborate the required training documentation.

Corrective Action: None.

Standard 115.333 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:
    a. *Institutional Services Section, PREA (Pages 9-10 of 21)*
4. Interviews with the following:
    a. Intake Staff
    b. Random Residents
5. Translation Contracts with:
    a. Hired Hands, Inc. (sign language);
    b. Language Consultants, Inc. (all except Spanish); and
    c. Universe Technical Translation (Spanish)
6. Resident Education Materials:
    a. *Safeguarding Your Sexual Safety* Video and *Facilitators Guide* (used for comprehensive PREA education)
    b. *Detention Center Orientation Handout (Rev. 4-23-15)*
    c. *Resident Orientation Handout*
7. On-site review of physical plant, specifically observing PREA Posters and educational materials in housing units, classrooms and common areas

Findings (By Subsection):

Subsection (a): TCJS policy requires residents receive information on PREA at the initial orientation process (i.e., intake). The information must be age-appropriate and include how to report sexual abuse or sexual harassment. Interviews with intake staff corroborate this is the practice. The Auditor reviewed the files of random residents and confirmed the intake education had occurred and was documented.

Subsection (b): Agency policy requires a comprehensive, age-appropriate education be provided to all residents within 10 days of intake. The facility schedules these training sessions every weekend and utilizes the *Safeguarding Your Sexual Safety* Video produced by the Texas Juvenile Justice Department. A staff member facilitates this educational session using the *Facilitator's Guide*. The Auditor reviewed the files of random residents and confirmed that the comprehensive education had occurred within 10 days of the resident's admission into the facility.

Subsection (c): All residents currently in the facility have received the PREA education required by this standard. All resident files reviewed by the Auditor contained documentation evidencing the provision of the PREA education as required by this standard.

Subsection (d): Agency policy requires that PREA information be made available and accessible to all residents including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as those residents who may have limited reading skills. The policy details how staff may access interpreters and the agency has contracts for sign language interpretation as well as regular language services. The agency has placed large PREA posters throughout the facility housing and common areas. These posters are on fiber board, very well-made and of high quality. PREA posters in the facility are displayed both in English and Spanish. The Auditor also noted that many of the classrooms had additional large laminated informational posters of high quality about sexual harassment, sexting, and suicidal thinking. These posters really supplement the main PREA posters and help create a culture of reporting and awareness of these issues.

Subsection (e): The Auditor reviewed multiple resident files and confirmed documentation of resident participation in the required education sessions.

Subsection (f): The agency ensures that key information about the agency's PREA policies is continuously and readily available or visible through posters, resident orientation materials, or other written formats. During the on-site review, the Auditor noted that PREA posters in the facility are displayed both in English and Spanish. Residents are allowed to keep the orientation material outside their individual rooms.

Corrective Action: None.

Standard 115.334 Specialized training: Investigations

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

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:
    a. *Institutional Services Section, PREA (Page 17 of 21)*
4. Interviews with the following:
    a. Investigative Staff
5. Training records for investigators

Findings (By Subsection):

Subsection (a): Agency policy requires employees assigned to conduct sexual abuse investigations to receive special training. TCJS has two staff members designed to conduct investigations. Both individuals attended the 2-day, Texas Juvenile Justice Department (TJJD) sponsored *Investigators Conference (11.50 training credit hours)* in June 2013. Interviews with the investigators confirm they attended this training; additionally, written documentation was submitted evidencing that both investigators attended and completed the TJJD training.

Subsection (b): Agency policy requires that the specialized training for investigators contain techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. The TJJD training contained this required material.

Subsection (c): The agency maintains documentation that the investigators attended and completed the required specialized training.

Corrective Action: None.

Standard 115.335 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:
    a. *Institutional Services Section, PREA (Pages 6-7 of 21)*
4. Interviews with the following:
    a. Medical and Mental Health Staff
5. Training records for Medical and Mental Health Staff
    a. Certificates of completion from National Institute of Corrections

Findings (By Subsection):

Subsection (a): Agency policy requires all full and part-time medical and mental health care practitioners have specialized training in the four detailed topics specified in this standard. This specialized training must be in addition to the regular training provided to all employees. The agency reports in the *PAQ* that they have seven individuals who work regularly at the facility and all have been trained. Documentation of completed training was submitted for all individuals. This training was taken online through the National Institute of Corrections course entitled *PREA: Behavior Health Care for Sexual Assault Victims in a Confinement Setting.* Certificates of completion were submitted for the seven staff. Interviews with medical staff corroborate they have had this training in addition to the general PREA training for regular employees. One additional staff member was unaccounted for in the *PAQ* and had not yet completed the training at the time of the on-site audit; however, the agency submitted documentation evidencing the completion of the training on April 29, 2016 so this standard is now fully compliant.

Subsection (b): Medical staff employed by the agency does not conduct forensic exams; all forensic exams are conducted off site by John Peter Smith Hospital SANE nurses. Therefore, this subsection is not applicable.

Subsection (c): TCJS maintains documentation of the specialized training for medical and mental health practitioners required by this standard. Written certificates of completion from the National Institute of Corrections were provided to the Auditor for review.

Subsection (d): A review of personnel files for medical and mental health practitioners (both employees and contract staff) showed that the general PREA training mandated for all employees had been provided to the specialized staff. This was in addition to the specialized training required for all medical and mental health practitioners.

Corrective Action: None.

Standard 115.341 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:
    a. *Institutional Services Section, Intake, Admissions & Release (Page 1 of 3)*
    b. *Institutional Services Section, PREA (Page 8 of 21)*
4. Interviews with the following:
    a. Staff Responsible for Risk Screening
    b. Random Residents
    c. PREA Coordinator
5. *TCJS Intake Behavioral Screening* (2 Pages)
6. *TCJS Mental Health Crisis Referral Form* (12/30/15 JF)
7. Resident Files

Findings (By Subsection):

Subsection (a): Agency policy requires screening for risk of sexual abuse victimization or sexual abusiveness toward other residents within 72 hours of the resident's arrival at the facility. The policy further requires this screening periodically throughout a resident's confinement. In the *PAQ*, the agency reports that in the past 12 months, 74 residents were screened. Interviews with staff responsible for conducting the intake screening indicate this is the practice of the facility; additionally, a review of resident files showed written documentation of the intake screening being completed on the *Intake Behavioral Screening* form within 72 hours. All files reviewed showed that the screening was done on the same day as the resident was admitted, usually within a couple of hours of admission. Interviews with residents revealed that the youth recall the screening being done when they first came to the facility. Although the agency policy states that periodic screenings will be conducted, a review of the resident files revealed that these screenings are not occurring and the agency really has no definitive procedure for defining when the periodic screening occurs. While secondary screenings may occur after an incident, there is no procedure in place to ensure that all residents receive periodic screenings throughout their stay in the facility.

Subsection (b): The agency utilizes the *Intake Behavioral Screening* form for the screening; the form appears to be an objective screening instrument.

Subsection (c): The *Intake Behavioral Screening* form attempts to ascertain information about the 11 mandatory topics defined and required in this subsection.

Subsection (d): Interviews with staff responsible for screening residents indicate that the required information is gathered through conversations with the resident during intake, from the screening instruments, classification assessments, court records, etc., and other relevant documents in the resident's file.

Subsection (e): Agency policy states that the information obtained during the behavior screening and classification planning shall be disseminated only to facility staff that needs such information to make mental health care or medical decisions, and safety and security decisions. Interviews with the PREA Coordinator reiterated that the information is considered highly confidential and is not disseminated to line officers unless there is a need to know.

Corrective Action: The following corrective actions are required to demonstrate compliance with this standard. All changes or modifications to policy and/or practice must be institutionalized through training of all relevant staff and demonstration of consistent application of the required policy/practice for a period of time. Documentation of the training and evidence of facility implementation of the new policy/practice must be submitted to the Auditor in writing.

1. The agency must develop a procedure to ensure that all residents receive periodic screenings throughout their stay in the facility. These screenings must be documented in the resident's file.

Verification of Corrective Action since the Audit

The Auditor was provided supplemental documentation to evidence and demonstrate the required corrective actions that were taken by the administration regarding this standard. This documentation is discussed below.

Additional Documentation Reviewed:

1. TCJS Policy:
    a. *Institutional Services Section, PREA (Pages 5)* Revised Policy Executed 9-21-16
2. *PREA Behavioral Health Screening Reassessment Log* (Began using on June 30, 2016)
3. Samples of Intake Behavior Health Screening (subsequent screenings)

The agency created a new policy and practice that requires upon intake, within 30 days and every 60 days throughout a resident's confinement, information will be obtained and used about the residents' personal history and behavior to reduce the risk of sexual abuse by or upon a resident through the facility objective screening instrument, follow up questions, intake behavioral screening form and medical health screening forms. The facility also began using a spreadsheet to track the reassessment process and the due dates for each youth to ensure that the 30 day and 60 day reassessments are performed as required. The only staff that are conducting the periodic screenings are the agency mental health staff, which includes two licensed psychologists and a LMSW. The clinical director trained the LMSW who conducts the majority of the screenings on the new periodic screening procedure. The Auditor reviewed additional subsequent screening forms for residents to evidence the new procedure. The facility is now fully compliant with this standard.

Standard 115.342 Use of screening information

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:
    a. *Institutional Services Section, Intake, Admissions & Release (Pages 1-2 of 3)*
    b. *Institutional Services Section, PREA (Page 9 of 21)*
4. Interviews with the following:
    a. PREA Coordinator
    b. Staff Responsible for Risk Screening
    c. Facility Administrator
    d. Medical and Mental Health Staff
    e. Staff who Supervise Residents in Isolation
5. *TCJS Intake Behavioral Screening* (2 Pages)
6. *TCJS Mental Health Crisis Referral Form* (12/30/15 JF)
7. Resident Files

Findings (By Subsection):

Subsection (a): Agency policy states that all information obtained upon intake and periodically throughout the residents' confinement will be used to make housing, bed, program and education assignments with the goal of keeping all residents safe and free from sexual abuse. Interviews with staff indicate this is the practice and a review of resident files also corroborate that the information ascertained at intake is being used appropriately.

Subsection (b): Agency policy states that residents are isolated only as a last resort when less restrictive measures are inadequate to keep them safe, and then only until an alternative can be arranged. The facility reports in the *PAQ* that in the past 12 months there have been no residents at risk of sexual victimization who have been placed in isolation. Interviews with staff indicate that isolation is not used for residents at risk of sexual victimization. Agency policy requires that residents in isolation must receive daily visits from a medical or mental health care clinician. Interviews with medical and mental health staff indicate that if isolation were ever used, the resident would receive a minimum of daily visits from medical and mental health practitioners and could potentially have multiple visits daily.

Subsection (c): Agency policy states that lesbian, gay, bisexual, transgender or intersex (LGBTI) residents are not placed in particular housing, bed, or other assignments solely on the basis of their identification as LGBTI. Also, the policy states that LGBTI status is not considered an indicator of likelihood of being sexually abusive. Interviews corroborate this is the practice and evidence that there are no designated housing units or areas for LGBTI youth. Interviews with LGBTI residents indicate they are in general housing and have not been placed in special housing for LGBTI youth.

Subsection (d): Agency policy provides that in making housing or programming assignments for transgender or intersex residents, the facility shall consider on a case-by-case basis whether the placement would ensure the resident's health and safety. Interviews with staff corroborate this will be the practice when the facility has a transgender or intersex resident.

Subsection (e): Agency policy requires that placement and programming assignments for each transgender or intersex resident must be reassessed at least twice each year to review any threats to safety experienced by the resident. While the agency has not had any transgender or intersex residents, the administration indicated this would be the practice.

Subsection (f): Agency policy states that a transgender or intersex resident's own view with respect to his/her own safety shall be given serious consideration. Interviews with staff indicate that this would be the practice when the

facility receives a transgender or intersex resident.

Subsection (g): Agency policy states that transgender or intersex resident shall be given the opportunity to shower separately from other residents. The Auditor discussed this specifically with the Facility Administrator who corroborated this would be the practice. The Facility Administrator also noted that they would also accommodate any resident who expressed fear or hesitation by allowing private showers.

Subsection (h): Agency policy requires documentation of the use of isolation for residents at risk of sexual victimization in compliance with this standard. The agency has no cases of isolation being used for this purpose in the past 12 months.

Subsection (i): Agency policy states that a review will be held every 10 days by the Facility Administrator to determine whether there is a continuing need for separation from the general population. This policy exceeds the standard which requires a 30-day review.

Corrective Action: None.

Standard 115.351 Resident reporting

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

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:
    a. *Institutional Services Section, PREA (Pages 10-11 of 21)*
4. Interviews with the following:
    a. Random Staff
    b. Random Residents
5. Resident Education Materials:
    a. *Safeguarding Your Sexual Safety Video* and Facilitators Guide (used for comprehensive PREA education)
    b. *Detention Center Orientation Handout (Rev. 4-23-15)*
    c. *Resident Orientation Handout*
6. On-site review of physical plant: observation in housing and common areas of PREA information available to residents

Findings (By Subsection):

Subsection (a): TCJS policy states the agency will provide multiple ways for residents to privately report sexual assault, abuse, harassment or retaliation by other residents or staff for reporting sexual abuse and sexual

harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. Residents may report to any staff member, via the facility grievance procedure, and by calling the abuse reporting line at the Texas Juvenile Justice Department (TJJD). All housing areas have a telephone room where the phones have a speed dial button that dials directly to TJJD. The Auditor tested the phones and called TJJD. Interviews with residents demonstrated the kids knew the ways to report and felt comfortable in doing so. Interviews with staff also indicate their knowledge of the reporting mechanisms available to the residents.

Subsection (b): Residents in the facility have access to report sexual abuse and sexual harassment to TJJD in Austin via the abuse reporting phone number. This number is on all the PREA posters throughout the facility and is found in the orientation materials provided to each resident. TJJD is a separate, independent and external state entity that provides oversight for juvenile justice facilities in Texas. The facility does not detain residents for civil immigration purposes. Interviews with staff and residents indicate knowledge of reporting to TJJD.

Subsection (c): Agency policy requires staff to accept reports made verbally in writing, anonymously, and from third parties. Staff must promptly document any verbal reports on a witness statement and follow their mandatory reporting procedures. Interviews with residents and staff indicate their knowledge of these reporting methods.

Subsection (d): Residents can make written reports of sexual abuse and sexual harassment by submitting a written grievance. Blank grievance forms are made available in each housing unit. Secure grievance boxes are also located in each housing unit for residents to submit their grievance. The Operations Manager or Shift Supervisor will check the grievance box daily prior to the end of the shift per agency policy. Interviews with staff corroborate this practice.

Subsection (e): Staff may privately report sexual abuse and sexual harassment of residents through the TJJD reporting line or to local law enforcement. Interviews with staff indicate they understand these reporting options available to them.

Corrective Action: None.

Standard 115.352 Exhaustion of administrative remedies

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

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. Interviews with the following:
    a. PREA Coordinator
4. Resident Education Materials:
    a. *Detention Center Orientation Handout (Rev. 4-23-15)*
    b. *Resident Orientation Handout*
    c. *Lynn W. Ross Juvenile Detention Center Grievance Procedures (Revised 12/09/15 RL)*

5. On-site review of physical plant: observation in housing and common areas of PREA information available to residents, specifically the grievance forms and secure deposit boxes

Findings (By Subsection):

Subsection (a): TCJS has a grievance process whereby residents can submit allegations of sexual abuse and sexual harassment. The grievance process is not compliant with this section because administration was not clear whether this section applied to their facility. Because the facility grievance process is one of the reporting mechanisms available to residents, this standard will apply. TCJS will need to amend their grievance process to ensure it is compliant with this standard and all the elements herein.

Subsection (b): The facility grievance procedures do not appear to put a time limit on the filing of a grievance for sexual abuse; however, the procedures do not address sexual assault at all. The procedure do tell residents to attempt to resolve the problem through discussion with the person with whom the resident is having the problem, so this directly violates this standard as it relates to sexual abuse allegations.

Subsection (c): The grievance procedures do not contain the protections contained in this subsection related to protecting the resident from having to submit the grievance to a staff member that may be the subject of the allegation. The grievance procedures/policy must be amended to contain the protections in this standard.

Subsection (d): The grievance procedures state that the grievance will be resolved within five days. This time frame exceeds the requirements of this subsection but it is unclear if this time frame was meant to apply when the grievance alleges sexual abuse. The procedures/policy should be reviewed with an eye toward a grievance for sexual abuse or sexual harassment.

Subsection (e): The grievance procedures do not address whether third parties may file a grievance on behalf of the resident as detailed in this subsection.

Subsection (f): The grievance procedures do not address emergency grievances at all or whether the facility has this practice.

Subsection (g): The grievance procedures do not address when a resident may be disciplined for filing a grievance in bad faith regarding sexual abuse.

Corrective Action: The following corrective actions are required to demonstrate compliance with this standard. All changes or modifications to policy and/or practice must be institutionalized through training of all relevant staff and demonstration of consistent application of the required policy/practice for a period of time. Documentation of the training and evidence of facility implementation of the new policy/practice must be submitted to the Auditor in writing.

1. TCJS should amend the grievance policy to include all the requirements included in this standard. Residents and staff must be re-trained on this policy and documentation of all policy changes and training must be submitted to the Auditor.

Verification of Corrective Action since the Audit

The Auditor was provided supplemental documentation to evidence and demonstrate the required corrective actions that were taken by the administration regarding this standard. This documentation is discussed below.

Additional Documentation Reviewed:

1. TCJS Policy:

   a. *Institutional Services Section, PREA (Pages 5)* Revised Policy Executed 9-21-16
2. *Detention Center Orientation (Revised 10-26)*
3. Completed Pre-Audit Questionnaire related to 115.352

The agency amended its grievance policy to include the requirements of the standard. Residents will be trained on the grievance process and emergency grievances during detention orientation and a new *Detention Center Orientation* sheet has been developed that includes the enhanced grievance process information. All detention operations managers have been trained on the new grievance process and they are training all their staff. The agency is now fully compliant with 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.

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:
   a. *Institutional Services Section, PREA (Pages 13, and 15-16 of 21)*
4. Interviews with the following:
   a. Random Residents
   b. Facility Administrator
   c. PREA Coordinator
   d. Director of Rape Crisis and Victim Services at Women's Center of Tarrant County
5. Resident Education Materials:
   a. *Detention Center Orientation Handout (Rev. 4-23-15)*
   b. *Resident Orientation Handout*
6. *TCJS Memorandum of Understanding* with the Women's Center of Tarrant County
7. On-site review of physical plant: observation in housing and common areas of PREA information available to residents, specifically the posters regarding the Women's Center of Tarrant County

Findings (By Subsection):

Subsection (a): Agency policy requires the facility to provide residents with access to outside victim advocates for additional emotional support services related to sexual abuse, by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll free hotline numbers where available. TCJS has a *Memorandum of Understanding* with the Women's Center of Tarrant County to provide these services to the residents of the facility. The Women's Center operates a 24-hour hotline for victims. Posters about the Women's Center are posted throughout the facility housing and common areas, generally in close proximity to the large PREA posters. The agency policy and the MOU both state that reasonable communication between the resident and the Women's Center will be held in a confidential manner as possible. Interviews with residents indicate they do not

understand that these services are available nor who provides them. While the posters are accessible, the residents do not have a good or even basic knowledge of the services of the Women's Center or how to access them. The agency must do additional, enhanced training and education of the residents on the availability of these services.

Subsection (b): Agency policy states that residents will be informed prior to access the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to the authorities in accordance with mandatory reporting laws. Interviews with residents indicate a lack of understanding of the services of the Women's Center and any confidentiality rules related to use of these services. The agency must enhance the education of residents to ensure understanding of the confidentiality rules.

Subsection (c): TCJS has an executed *Memorandum of Understanding* with the Women's Center which was executed on February 18, 2016. The Auditor spoke to the Women's Center and confirmed the MOU and the services that would be provided. The MOU can be renewed every two years.

Subsection (d): Agency policy provides that residents shall have reasonable and confidential access to their attorneys or other legal representation and have reasonable access to parents/legal guardians. Interviews with agency administration indicate a liberal visitation policy at the facility. Interviews with residents corroborate frequent and liberal visitation is the practice at the facility.

Corrective Action: The following corrective actions are required to demonstrate compliance with this standard. All changes or modifications to policy and/or practice must be institutionalized through training of all relevant staff and demonstration of consistent application of the required policy/practice for a period of time. Documentation of the training and evidence of facility implementation of the new policy/practice must be submitted to the Auditor in writing.

1. TCJS must enhance and strengthen its education of residents regarding the access to outside victim advocates for emotional support services. Residents must also be given sufficient information to understand the confidentiality parameters related to accessing these services. This could be done through additional discussions at the comprehensive PREA training done on the weekends, by the counseling staff, by providing brochures about the services that the residents can keep, etc. Frequently, organizations such as the Women's Center are willing to come into the facility and make presentations to the residents to help with an understanding of the services available; these presentations could possibly be filmed and reused for presentations to future residents.

Verification of Corrective Action since the Audit

The Auditor was provided supplemental documentation to evidence and demonstrate the required corrective actions that were taken by the administration regarding this standard. This documentation is discussed below.

Additional Documentation Reviewed:

1. *Tarrant County Juvenile Services Resident Orientation Handout (Revised)*
2. RAINN (Rape, Abuse, Incest National Network) at 1-800-656-HOPE (4673); RAINN website at www.rainn.org
3. New RAINN Posters displayed in the facility with toll-free number and website address

The agency has updated its orientation handout to include information about the Rape, Abuse, Incest National Network (RAINN). New posters have been placed in the facility to provide the toll-free number for RAINN to residents and this information is now stressed at intake orientation. The facility is now fully compliant with this standard.

Standard 115.354 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:
    a. *Institutional Services Section, PREA (Pages 12-13 of 21)*
4. *Agency website:* http://access.tarrantcounty.com/en/juvenile-services/division-listing/detention/detention-visitation-schedule/PREA.html?linklocation=Iwantto&linkname=Information about PREA

Findings (By Subsection):

Subsection (a): TJCS provides a method to receive third-party reports of resident sexual abuse or sexual harassment. Agency policy states that third-party reports of sexual abuse and sexual harassment shall be made by calling the Texas Juvenile Justice Department Abuse Hotline number at 1-877-7786-7263. The agency website contains this information for the public. The Auditor also recommends that the parents or legal guardians of residents be given this information in writing at intake. This could be done through the provision of a custom handout or the TJJD brochure on reporting abuse.

Corrective Action: None.

Standard 115.361 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:

a. *Institutional Services Section, PREA (Pages 8, and 12-15 of 21)*

4. Interviews with the following:
    a. Random Staff
    b. Medical and Mental Health Staff
    c. PREA Coordinator
    d. Facility Administrator
5. Internal investigative report
6. Texas Family Code
7. Title 37 Texas Administrative Code Chapter 343

Findings (By Subsection):

Subsection (a): The agency has a policy that requires all staff, including medical and mental health providers, to report sexual abuse to the Facility Administrator, PREA Coordinator, Sherriff's Department and the Texas Juvenile Justice Department (TJJD). Additionally, all mandatory reporting laws must be followed. Interviews with staff indicate a clear and comprehensive understanding of the mandatory reporting laws (including timeframes), state standards and PREA requirements that apply to the facility.

Subsection (b): Agency policy requires compliance with all mandatory child abuse reporting laws in Texas. All child abuse allegations must be reported to TJJD and local law enforcement per the Texas Family Code and TJJD administrative rules. Interviews with staff indicate they understand these requirements; staff is able to articulate clearly to the Auditor their responsibilities to report and the mandatory time frames set in law.

Subsection (c): Agency policy states that staff shall keep any information confidential related to the sexual abuse report. The information cannot be revealed to anyone other than to the extent necessary to make treatment, investigation and other security management decisions. Interviews with facility administration indicate their practice is to ensure confidentiality of all information. Tarrant County utilizes the *Juvenile Case Management System (JCMS Techshare Juvenile)* which has role-based security access; this system ensures that confidential information about a resident is available only to those whose role requires access.

Subsection (d): Agency policy requires medical and mental health providers to report abuse to the Facility Administrator, PREA Coordinator, Sherriff's Department and TJJD. Additionally, all mandatory reporting laws must be followed. Additionally, agency policy requires medical and mental health providers to inform residents at the initiation of services of their duty to report and the limitations of confidentiality regarding information gathered. Interviews with medical and mental health staff indicate this is their practice.

Subsection (e): Agency policy details the mandatory reporting to the victim's parents or legal guardians, the child welfare system, and the juvenile court as required by this subsection. Interviews with the PREA Coordinator and the Facility Administrator indicate that the notifications required in this subsection are facility practice.

Subsection (f): Agency policy requires all allegations to be investigated by the agency investigator. The Auditor interviewed the Facility Administrator who confirmed this practice.

Corrective Action: None.

Standard 115.362 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ*) and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:
    a. *Institutional Services Section, PREA (Page 10 of 21)*
4. Interviews with the following:
    a. Agency Head
    b. Random Staff
    c. Facility Administrator

Findings (By Subsection):

Subsection (a): In the *PAQ*, the agency reports that in the past 12 months, there have been no instances where the facility has determined that a resident was subject to a substantial risk of imminent sexual abuse. The header to the agency policy on reporting states that when a resident is subject to a substantial risk of imminent sexual abuse, immediate action will be taken to protect the resident. The policy gives no further detail on what those actions could be. It is recommended that the policy be enhanced to include possible actions that the facility could take such as housing changes, etc. However, in interviews with the Agency Head, Facility Administrator and other staff, it was clear that the facility would indeed take appropriate protective measures. All interviewed could clearly articulate a variety of possible protective measures that would be considered if a resident was at risk of imminent sexual abuse.

Corrective Action: None.

Standard 115.363 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:
    a. *Institutional Services Section, PREA (Page 15 of 21)*
4. Interviews with the following:

a. Agency Head
b. Facility Superintendent

Findings (By Subsection):

Subsection (a): Agency policy requires that the Facility Administrator notify the administrator of another facility where an allegation of alleged abuse occurs as required by this subsection. In the *PAQ*, the facility reports that in the past 12 months they have received no allegations of abuse of a resident while confined at another facility; therefore, there have been no instances where the facility had to report to another institution. Interviews with the Agency Head and Facility Administrator indicate that this notification would be the practice of the facility in the event of an allegation received about another facility.

Subsection (b): Policy requires the notification to occur as soon as possible but no later than 72 hours after receipt of the allegation. Interviews confirm this would be the practice.

Subsection (c): Policy requires documentation of the notification. Interviews confirm this would be the practice.

Subsection (d): Policy requires that the facility that receives such notification will ensure the allegation is investigated in accordance with PREA standards. Interviews indicate that if TCJS received such notification, the normal investigation process would be initiated as with any allegation of abuse.

Corrective Action: None.

Standard 115.364 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:
    a. *Institutional Services Section, PREA (Page 15 of 21)*
4. Interviews with the following:
    a. First Responder Staff
    b. Facility Superintendent
    c. Random Staff
5. Training Documentation:
    a. First Responder Training (PowerPoint Presentation)
    b. Staff First Responder Training sign-in sheets

Findings (By Subsection):

Subsection (a): Agency policy details the duties of a first responder in compliance with this standard. The facility reports in the *PAQ* that in the past 12 months, there have been no allegations of sexual abuse; therefore, there have been no situations where the protocol was used and crime scene and physical evidence protection occurred. Interviews with staff indicate they are very knowledgeable on their role as a first responder and staff are able to articulate exactly what they would do if they were the first responder to a sexual abuse allegation that had occurred onsite.

Subsection (b): Agency policy details what a non-security staff first responder should do in compliance with this subsection. Interviews corroborate that staff understand their first responder protocols.

Corrective Action: None.

Standard 115.365 Coordinated response

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

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. *TCJS Institutional Response Team Protocol for Sexual Assault (5 Page Document)*
    a. *Supervisor Checklist for Allegations of Sexual Abuse/Sexual Harassment*
    b. *First Responder's & Operations Manager Checklist*
    c. *TCJS—PREA Incident Response Plan* (flowchart)
4. Interviews with the following:
    a. Facility Administrator
    b. PREA Coordinator

Findings (By Subsection):

Subsection (a): TCJS has developed an institutional response plan that is five pages in length. It includes checklists to help ensure all required steps are followed. Additionally, it includes a flowchart that depicts the flow of responsibilities in the event of an incident of sexual abuse. The plan is compliant with this standard. The Auditor recommends that the facility conduct mock incident exercises (table top exercise) and have all relevant parties participate (e.g., law enforcement, SANE nurse, victim advocate, key agency staff). Walking through the plan with all who are involved and discussing the flow ensures no surprises and that everyone is clear on the responsibilities.

Corrective Action: None.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

☒ Not Applicable

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. Interviews with the following:
    a. Agency Head

Findings (By Subsection):

Subsection (a): Tarrant County and TCJS have no collective bargaining agreements so this standard is not applicable.

Corrective Action: None.

Standard 115.367 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:
    a. *Institutional Services Section, PREA (Page 13 of 21)*
4. Interviews with the following:
    a. Agency Head
    b. Facility Administrator
    c. Staff Member Charged with Monitoring Retaliation

Findings (By Subsection):

Subsection (a): TCJS has a policy to protect all residents and staff who report sexual abuse or sexual harassment or who cooperate with investigations from retaliation by other residents or staff. The Facility Administrator is designated to monitor retaliation toward residents or staff. The policy details four items that shall be monitored: 1) resident disciplinary reports; 2) unit housing; 3) program changes; and 4) negative performance reviews or reassignment of staff. The agency has designated the Operations Managers as the individuals who will conduct periodic status checks of residents. In the *PAQ*, the agency reports that in the past 12 months there have been no incidents of retaliation or feared retaliation.

Subsection (b): Agency policy details multiple protective measures such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims. Policy further provides that emotional support services will be provided to staff and residents who report sexual abuse or sexual harassment and who fear retaliation. Interviews with agency administration confirm this would be the practice.

Subsection (c): Agency policy requires monitoring for at least 90 days following a report of sexual abuse. Interviews with administration corroborates this would be the practice.

Subsection (d): Agency policy requires periodic status checks to be conducted by the Operations Managers randomly twice weekly and documented. Interviews indicate this would be the practice.

Subsection (e): Agency policy states that if an individual who cooperates with an investigation expresses a fear of retaliation, the facility shall take appropriate measures to protect the individual against retaliation. Interviews with agency administration confirm this would be the practice.

Corrective Action: None.

Standard 115.368 Post-allegation protective custody

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

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:
    a. *Institutional Services Section, PREA (Page 14 of 21)*
4. Interviews with the following:
    a. Facility administrator
    b. Staff Who Supervise Residents in Isolation
    c. Medical and Mental Health Staff
5. On-site review of physical plant, observing use of isolation

Findings (By Subsection):

Subsection (a): Agency policy requires that residents who alleged to have suffered sexual abuse may only be placed in isolation as a last resort if less restrictive measures are inadequate to keep them safe, and only until alternative means of keeping all residents safe can be arranged. In the *PAQ*, the facility reports that in the past 12 months there have been no resident victims placed in isolation. Interviews with agency administration and staff indicate that isolation of resident victims is not used. During the on-site review, the Auditor observed only the use of short-term, behavioral isolation.

Corrective Action: None.

Standard 115.371 Criminal and administrative agency investigations

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

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:
    a. *Institutional Services Section, PREA (Pages 17-19 of 21)*
4. Interviews with the following:
    a. Investigative Staff
5. Sample investigative report for allegation of sexual abuse (dated February 5, 2013)
6. Training records for agency investigators

Findings (By Subsection):

Subsection (a): The agency has a policy governing administrative investigations; additionally, the conduct of these investigations is regulated by the Texas Juvenile Justice Department (TJJD) via their administrative rules. Policy requires the investigations to be done promptly, thoroughly and objectively for all allegations, including third-party and anonymous. The facility reports there have been no internal administrative investigations for sexual abuse or sexual harassment in the past 12 months; thus, the Auditor had no recent investigations to review. However, the Auditor did review an investigation from 2013 to determine if the requirements of this standard were met. All requirements of this standard were met and the Auditor found the investigation report to be exemplary in content and form.

Subsection (b): The agency has designated two individuals as the investigators for the agency. Agency policy requires that all investigators receive special training as required by Standard 115.334. Both investigators attended the *Investigator's Conference* presented by TJJD in June 2013 and the agency submitted training verification documents to evidence this. Interviews with investigative staff corroborate the training was received.

Subsection (c): Agency policy requires the investigators to gather and preserve evidence, interview all pertinent parties, and review prior complaints and reports of sexual abuse involving the suspected perpetrator as required by this subsection. Review of the sample investigative report of the agency revealed that these requirements were met.

Subsection (d): Agency policy states an investigation shall not terminate solely because the source of the allegation recants. Interviews with investigative staff indicate this is the practice.

Subsection (e): Agency policy states that the Tarrant County Sheriff's Office will conduct all interviews in cases where the conduct appears to be criminal. TCJS does not conduct compelled interviews of staff.

Subsection (f): Agency policy states that the credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person's status as resident or staff. Interviews with investigative staff confirm this is the practice.

Subsection (g): Agency policy requires investigations to include an effort to determine if staff actions or failure to act contributed to the abuse. Investigations must be documented on the TJJD incident form and shall describe the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. Interviews with investigative staff confirm this is the practice.

Subsection (h): Agency policy requires that criminal investigations be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible. The criminal reports by the Sheriff's Office adhere to these requirements. TCJS does not conduct criminal investigations.

Subsection (i): TCJS policy requires that substantiated allegations of conduct that appear to be criminal shall be referred for prosecution to the Sheriff's Office. Interviews with investigative staff confirm this is the practice.

Subsection (j): Agency policy contains the required records retention period as detailed in this subsection.

Subsection (k): Agency policy states that the departure of the alleged perpetrator or victim from the employment or control of the facility shall not provide a basis for terminating an investigation. Interviews with investigative staff confirm this is the practice.

Subsection (m): Agency policy requires the PREA Coordinator to request the relevant information from an outside investigative agency (i.e., Sheriff's Office and TJJD) in order to inform the resident of the progress of the investigation. Interviews with investigative staff confirm this is the practice.

Corrective Action: None.

Standard 115.372 Evidentiary standard for administrative investigations

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

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:
    a. *Institutional Services Section, PREA (Page 18 of 21)*
4. Interviews with the following:
    a. Investigative Staff
5. Sample investigative report for allegation of sexual abuse (dated February 5, 2013)

Findings (By Subsection):

Subsection (a): Agency policy states that no standard higher than a preponderance of evidence is required to determine whether allegations of sexual abuse or sexual harassment are substantiated. Interviews with investigative staff confirm this is the practice. Additionally, a review of a sample investigation of sexual abuse revealed that the correct standard of evidence was utilized.

Corrective Action: None.

Standard 115.373 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:
    a. *Institutional Services Section, PREA (Page 18 of 21)*
4. Interviews with the following:
    a. Investigative Staff
    b. Facility Administrator
5. Sample investigative report for allegation of sexual abuse (dated February 5, 2013)

Findings (By Subsection):

Subsection (a): Agency policy requires notification of the resident victim of abuse as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. Interviews with staff indicate this notification is the practice of the facility when there are investigations. In the *PAQ*, the agency reports that during the past 12 months there have been no criminal or administrative investigations because there have been no allegations of sexual abuse or sexual harassment.

Subsection (b): Agency policy states that if the facility did not conduct the investigation, the PREA Coordinator will request the relevant information from the investigative agency to inform the resident. Interviews with agency staff indicate this is the practice.

Subsection (c): Agency policy requires the notifications to the resident victim regarding dispositions of the case against an alleged staff perpetrator as required by this subsection. Because there have been no investigations in the past 12 months, there have been no notifications under this subsection.

Subsection (d): Agency policy requires the notifications to the resident victim regarding dispositions of the case against an alleged resident perpetrator as required by this subsection. Because there have been no investigations in the past 12 months, there have been no notifications under this subsection. It is recommended that the agency enhance and correct its policy by adding notification requirements if the alleged resident perpetrator is "indicted". If the resident perpetrator was 17 at the time of the conduct, the perpetrator would be in the adult system and thus face indictment. This may change if Texas raises the age of jurisdiction to 18 in the future, in which case the perpetrator would not face indictment.

Subsection (e): Agency policy requires all notifications or attempted notifications to be documented.

Corrective Action: None.

Standard 115.376 Disciplinary sanctions for staff

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

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:
    a. *Institutional Services Section, PREA (Page 19 of 21)*
4. Interviews with the following:
    a. PREA Coordinator
    b. Facility Administrator

Findings (By Subsection):

Subsection (a): Agency policy provides staff is subject to disciplinary sanctions for violating agency sexual abuse or sexual harassment policies. Discipline may include termination. The agency reports in the *PAQ* that in the past 12 months, there have been no employees disciplined for violating sexual abuse or sexual harassment policies.

Subsection (b): Agency policy provides that termination shall be the presumptive disciplinary sanction for employees who engage in sexual abuse. No employees have been terminated in the past 12 months for PREA related violations.

Subsection (c): Agency policy requires the staff discipline be commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. There have been no employees disciplined in the past 12 months for PREA related conduct.

Subsection (d): Agency policy states that all terminations for violations of facility sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignations, shall be reported to law enforcement, unless the activity was clearly not criminal, and to the Texas Juvenile Justice Department (TJJD) who certifies officers. The Auditor recommends that the policy be enhanced to require notification to any "relevant licensing bodies" which could include regulatory agencies for licensed counselors, medical professionals, etc. While TJJD is certainly the main organization that regulates employees in the facility, it is not the only entity that could require notification. The agency policy does require notification to relevant licensing bodies for volunteers and contractors; however, there are some actual employees (not volunteers or contractors) of the facility that are not certified by TJJD but do hold licensure from other state agencies.

Corrective Action: None.

Standard 115.377 Corrective action for contractors and volunteers

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

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:
    a. *Institutional Services Section, PREA (Page 19 of 21)*
4. Interviews with the following:
    a. PREA Coordinator
    b. Facility Administrator

Findings (By Subsection):

Subsection (a): Agency policy states that any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with residents and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. The facility reports in the *PAQ* that in the past 12 months, there have been no contractors or volunteers who have been subjected to corrective action for engaging in sexual abuse or sexual harassment of residents.

Subsection (b): Agency policy states that the facility shall take appropriate remedial measures, and shall consider whether to prohibit further contact with residents, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer. Interviews with agency administration corroborate this would be the practice of the facility in the event of a violation by a contractor or volunteer.

Corrective Action: None.

Standard 115.378 Disciplinary sanctions for residents

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

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:
    a. *Institutional Services Section, PREA (Page 14 of 21)*
4. *Resident Discipline Plan*
5. Interviews with the following:
    a. PREA Coordinator
    b. Facility Administrator
    c. Medical and Mental Health Staff

Findings (By Subsection):

Subsection (a): Agency policy states that a resident may be subject to disciplinary sanctions only pursuant to a formal disciplinary process as outlined in the *Resident Discipline Plan* following a finding that the resident engaged in resident-on-resident sexual abuse. The facility reports in the *PAQ* that in the past 12 months, there have been no administrative or criminal findings of resident-on-resident sexual abuse in the facility.

Subsection (b): Agency policy states that disciplinary sanctions shall be commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offense by other residents with similar histories. Agency policy further states that if a resident is isolated, the following isolation requirements will be followed: Residents in isolation shall receive daily large-muscle exercise, access to educational programming or special education services and daily visits from a medical or mental health care provider. Residents shall also have access to other programs to the extent possible. Interviews with agency staff indicate this is the practice of the facility.

Subsection (c): Agency policy states that the disciplinary process shall consider if the resident's mental disabilities or mental illness contributed to the behavior when determining what sanction, if any, is imposed. Interviews with agency staff indicate this is the practice of the facility.

Subsection (d): Agency policy states that the facility will determine if the resident will receive counseling or other interventions to address and correct underlying reasons or motivations for the abuse. The facility shall consider whether to offer the offending resident participation in such interventions. Policy further states that the facility may require participation in interventions as a condition of access to privileges within the program but not as a condition to access to general programming or education. Interviews with mental health staff indicate compliance with this subsection ensuring residents have access to general programming and education regardless of whether the resident participates in the other interventions.

Subsection (e): Agency policy states that a resident may be disciplined for sexual contact with staff only upon a finding that the staff did not consent to such contact. The facility reports that in the past 12 months, there have been no residents disciplined for this type conduct.

Subsection (f): Agency policy states that a report made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.

Subsection (g): Agency policy states that sexual activity between residents is strictly prohibited and residents may be disciplined for such activity. This policy should be enhanced to include the last sentence of Subsection (g) which states "An agency may not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced."

Corrective Action: None.

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

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

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:
    a. *Institutional Services Section, PREA (Pages 8 and 11 of 21)*
4. *TCJS Mental Health Crisis Referral Form (12/30/15 JF)*
5. Interviews with the following:
    a. Residents who Disclose Sexual Victimization at Risk Screening
6. Resident Files

Findings (By Subsection):

Subsection (a): Agency policy states that if any of the intake screening forms indicates a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, the

intake officer shall document the information on the behavior health screening or medical health screening form and provide a copy of the form(s) to the Operations Manager or the Designated Shift Supervisor and the mental health provider. Policy further states that if required, a follow up meeting with the mental health care provider will be held within 14 days of the intake screening. In the *PAQ*, the facility indicates that in the past 12 months there have been eight (8) residents that have disclosed prior victimization during screening; 100% of these residents were offered a follow-up meeting with a medical or mental health practitioner. Interviews with screening staff corroborate this practice. The Auditor reviewed several resident files for youth who had disclosed prior sexual victimization and confirmed that each resident had received a *Mental Health Crisis Referral* Form which is completed by staff and referred to medical/mental health practitioners in order for the resident to be seen. It is recommended that the language in the policy be clarified to ensure that policy explicitly requires the follow-up meeting. The "If required" language is confusing and misleading potentially; it is clearly the practice of the facility is to provide the follow-up to residents who disclose and the policy should be enhanced and conformed to match the practice.

Subsection (b): Agency policy states that if the behavior screening indicates the resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, staff shall ensure the resident is offered a follow-up meeting with a mental health provider within 14 days of the intake screening. In the *PAQ*, the facility indicates that in the past 12 months there have been two (2) residents that have disclosed during screening that they had previously perpetrated abuse; 100% of these residents were offered a follow-up meeting with a medical or mental health practitioner. Interviews with screening staff corroborate this practice.

Subsection (c): Agency policy states that any information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to medical and mental health providers and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law. Youth files are kept securely in the intake area of the facility with very limited access to select staff with a need to know. The automated JCMS also has very strict role-based security so that resident information cannot be accessed accept by individuals with a business need to know.

Subsection (d): Agency policy states that medical and mental health providers shall inform residents at the initiation of services of their duty to report and the limitations of confidentiality regarding information gathered. Interviews with medical and mental health staff indicate this is their practice.

Corrective Action: None.

Standard 115.382 Access to emergency medical and mental health services

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

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:
    a. *Institutional Services Section, PREA (Page 16 of 21)*
4. Interviews with the following:
    a. Medical and Mental Health Staff
    b. First Responder Staff

Findings (By Subsection):

Subsection (a): Agency policy states that resident victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The nature and scope of these services are determined by medical and mental health providers according to their professional judgment. In the *PAQ*, the agency reports no incidents where there have been victims requiring these services. Interviews with medical and mental health personnel confirm that all victims would receive these services.

Subsection (b): Agency policy states that if a medical or mental health practitioner is not on duty at the time of the report, the first responder shall take preliminary steps to protect the victim and shall immediately notify the appropriate medical and mental health providers. Interviews with first responder staff confirm knowledge of first responder duties in this situation.

Subsection (c): Agency policy states that resident victims of sexual abuse while detained shall be offered timely information about and timely access to pregnancy tests, emergency contraception and sexually transmitted infections prophylaxis in accordance with professionally accepted standards of care, where medically appropriate. The policy further states that this care will be provided by John Peter Smith Hospital in Ft. Worth. Medical staff interviews corroborate this would be the practice.

Subsection (d): Agency policy provides that treatment services shall be provided to the victim without financial cost and regardless if the victim names the abuser or cooperates with any investigation arising from the incident. Interviews with medical staff confirm these services are provided without cost to the victim.

Corrective Action: None.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:

a. *Institutional Services Section, PREA (Page 16 of 21)*

4. Interviews with the following:
    a. Medical and Mental Health Staff

Findings (By Subsection):

Subsection (a): Agency policy states that the facility shall offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in a juvenile facility. This policy should be enhanced to include the language "prison, jail and lockup" as it is possible for a juvenile to have been in these facilities technically. Interviews with medical and mental health staff indicate this would be the practice.

Subsection (b): Agency policy states that the evaluation and treatment shall include, as appropriate, follow-up services, treatment plans, and when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. Interviews with medical and mental health staff indicate this would be the practice.

Subsection (c): Agency policy states that medical and mental health services shall be provided to the victims consistent with the community level of care. Interviews with medical and mental health staff indicate this would be the practice.

Subsection (d): Agency policy states that resident victims of sexually abusive vaginal penetration while in detention shall be offered pregnancy tests. Interviews with medical staff indicate this would be the practice.

Subsection (e): Agency policy states that if pregnancy results from the abuse, the victim shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services. Interviews with medical staff indicate this would be the practice.

Subsection (f): Agency policy states that resident victims of sexual abuse while in detention shall be offered tests for sexually transmitted infections as medically appropriate. Interviews with medical staff indicate this would be the practice.

Subsection (g): Agency policy states that treatment services shall be provided to the victim without financial cost and regardless if the victim names the abuser or cooperates with any investigation arising out of the incident. Interviews with medical and mental health staff indicate this would be the practice.

Subsection (h): Agency policy states that the facility shall attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health providers. Policy further states that the facility mental health providers will make a recommendation on the length of treatment needed. Interviews with medical and mental health staff confirm this would be the practice.

Corrective Action: None.

Standard 115.386 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Completed Pre-Audit Questionnaire (PAQ)
4. TCJS Policy:
    a. *Institutional Services Section, PREA (Page 20 of 21)*
5. Interviews with the following:
    a. Facility Administrator
    b. PREA Coordinator
    c. Incident Review Team Members
6. March 2016 Meeting Agenda where Incident Review Team was created; Sign-in sheet from meeting

Findings (By Subsection):

Subsection (a): Agency policy states that the facility shall conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded. The facility reports in the *PAQ* that during the past 12 months there have been no allegations of sexual abuse; thus, no sexual abuse incident reviews have occurred as of yet since this new policy has been put into place. The Auditor recommends that the review team meet periodically even if there are no allegations to review to discuss PREA issues, the reporting culture, and any enhancements to the sexual safety of the facility.

Subsection (b): Agency policy states that the incident reviews shall ordinarily occur within 30 days of the conclusion of the investigation. Interviews with agency administration confirm this will be the practice for the facility.

Subsection (c): Agency policy details the membership of the review team as including the Chief Juvenile Probation Officer, Deputy Director, Facility Administrator, and PREA Coordinator (who is also the investigator) with input from Operations Managers, and medical and mental health providers. Interviews with agency administration confirm this will be the practice for the facility.

Subsection (d): Agency policy details all the responsibilities of the review team in compliance with this subsection. Interviews with members of the review team confirm their knowledge of their responsibilities on the team.

Subsection (e): Agency policy states that the Facility Administrator shall implement the recommendations for improvement, or shall document the reasons for not doing so. The review team has not yet met because the facility has had no allegations/investigations of sexual abuse in the past 12 months.

Corrective Action: None.

Status of Recommendations. The agency Incident Review Team has begun meeting periodically even when there are no incidents as recommended by the Auditor. The facility submitted to the Auditor a meeting agenda and sign-in sheet from their September meeting to evidence they have implemented this recommendation.

Standard 115.387 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:
    a. *Institutional Services Section, PREA (Pages 1-3 and 20 of 21)*
4. *TCJS Data Collection Tool*
5. *Report Based on the Annual Survey of Sexual Violence for Tarrant County Juvenile Services (showing aggregated data 2012-2015)*

Findings (By Subsection):

Subsection (a) and (c): Agency policy states that the facility shall collect accurate, uniform data for every allegation of sexual abuse at the facility using the annual PREA report form developed by the facility. Policy further states that the incident-based data collected shall include, at a minimum, the data necessary to answer all questions from the most recent version of the *Survey of Sexual Violence* conducted by the Department of Justice.

Subsection (b): Agency policy states that the facility shall aggregate the incident-based sexual abuse data at least annually. Review of the aggregated report demonstrates data is being collected and aggregated annually and has gone back to 2012.

Subsection (d): Agency policy states that the facility shall maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

Subsection (e): Agency policy does not state that the agency shall also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents. Interviews with agency administration indicate that this will be done in the future for all contracts that are currently being renewed/renegotiated.

Subsection (f): Agency policy states that upon request, the facility shall provide all such data from the previous calendar year to the Department of Justice no later than June 30.

Corrective Action: The following corrective actions are required to demonstrate compliance with this standard. All changes or modifications to policy and/or practice must be institutionalized through training of all relevant staff and demonstration of consistent application of the required policy/practice for a period of time. Documentation of the training and evidence of facility implementation of the new policy/practice must be submitted to the Auditor in writing.

1. TCJS must obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents. This requirement should be added to the agency policy to enhance it.

Verification of Corrective Action since the Audit

The Auditor was provided supplemental documentation to evidence and demonstrate the required corrective actions that were taken by the administration regarding this standard. This documentation is discussed below.

Additional Documentation Reviewed:

1. TCJS Policy:
   - **a.** *Institutional Services Section, PREA (Pages 5)* Revised Policy Executed 9-21-16
2. *Tarrant County Juvenile Services Status of Residential Contract Providers in Becoming PREA Certified*
3. *Executed Residential Services Contract (September 1, 2016 to September 1, 2017) for Clarinda Academy*
4. Data Collection Spreadsheet
5. *2016 Annual PREA Report (showing 2014 and 2015 data)*
6. *Tarrant County website posting of PREA Report*: http://access.tarrantcounty.com/content/dam/main/juvenile-services/Documents/2016_PREA_Annual_Report.pdf?linklocation=Annual Report&linkname=2016 PREA Annual Report

The agency has redone all its contracts with residential service providers to explicitly include all the PREA requirements including data collection. They have received data from all facilities for 2015 and this information is included in the 2016 Annual PREA Report which is published on the agency website. All providers are required to submit this data in June of each year to the agency. The agency is requesting that all providers send a copy of their completed Survey of Sexual Victimization data form. The agency is now fully compliant with this standard.

Standard 115.388 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:
   a. *Institutional Services Section, PREA (Pages 1-3 and 20 of 21)*
   b. *Institutional Services Section, Detention (Page 1 of 4)*
4. Interviews with the following:
   a. Agency Head
   b. PREA Coordinator
5. *Report Based on the Annual Survey of Sexual Violence for Tarrant County Juvenile Services* (showing

aggregated data 2012-2015)
6. Agency Website Publication of Annual Report: http://access.tarrantcounty.com/content/dam/main/juvenile-services/Documents/2015_Annual_PREA_report.pdf?linklocation=Button List&linkname=2015 Annual Report

Findings (By Subsection):

Subsection (a): TCJS policy requires the agency to review data collected and aggregated pursuant to Standard 115.387 to assess and improve the effectiveness of the sexual abuse prevention, detection, and response policies, practices, and training as required by this section. The Auditor reviewed the annual report for compliance.

Subsection (b): The TCJS annual report includes a comparison of the current year's data and prior years (2012-2015). The report provides an assessment of the agency's progress in addressing sexual abuse.

Subsection (c): Agency policy states that the report shall be approved by the Facility Administrator and made readily available to the public through the facility website (www.tarrantcounty.com). The interview with the Agency Head confirmed that he approves this report prior to publication on the website.

Subsection (d): Agency policy states that the facility may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility, but must indicate the nature of the material redacted. Interviews with the PREA Coordinator indicate this is facility practice.

Corrective Action: None.

Standard 115.389 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. TCJS Completed *Pre-Audit Questionnaire (PAQ)* and supporting documentation provided
2. TCJS Responses to *Issue Log* questions from Auditor and supplemental documentation provided
3. TCJS Policy:
    a. *Institutional Services Section, Detention* (Page 1 of 4)
4. Interviews with the following:
    a. PREA Coordinator
5. *Report Based on the Annual Survey of Sexual Violence for Tarrant County Juvenile Services (showing aggregated data 2012-2015)*
6. Agency Website Publication of Annual Report: http://access.tarrantcounty.com/content/dam/main/juvenile-services/Documents/2015_Annual_PREA_report.pdf?linklocation=Button List&linkname=2015 Annual Report

Findings (By Subsection):

Subsection (a): Agency policy states that the facility shall ensure that data collected pursuant to Standard 115.387 are securely retained. The PREA Coordinator confirmed this practice.

Subsection (b): Agency policy states that the facility shall make all aggregated sexual abuse data, readily available to the public at least annually through the county website. This policy fails to require the aggregation of data from facilities with which TCJS contracts. The annual report does not contain data from these facilities.

Subsection (c): Agency policy states that before making aggregated sexual abuse data publicly available, the facility shall remove all personal identifiers. The annual report complies with this requirement.

Subsection (d): Agency policy states that the facility shall maintain sexual abuse data collected pursuant to Standard 115.387 for at least 10 years after the date of initial collection unless Federal, State, or local law requires otherwise. Agency administration confirms this is the practice.

Corrective Action: The following corrective actions are required to demonstrate compliance with this standard. All changes or modifications to policy and/or practice must be institutionalized through training of all relevant staff and demonstration of consistent application of the required policy/practice for a period of time. Documentation of the training and evidence of facility implementation of the new policy/practice must be submitted to the Auditor in writing.

1. TCJS must aggregate sexual abuse data from private facilities with which it contracts and make this data available to the public at least annually through its website. The Facility Administrator notified the Auditor on April 29, 2016 that they have identified all their contract residential placements required to be PREA compliant and will be sending a request May 2, 2016 for aggregate data and an update on their PREA compliance status.

Verification of Corrective Action since the Audit

The Auditor was provided supplemental documentation to evidence and demonstrate the required corrective actions that were taken by the administration regarding this standard. This documentation is discussed below.

Additional Documentation Reviewed:

1. *2016 Annual PREA Report (showing 2014 and 2015 data)*
2. *Tarrant County website posting of PREA Report:* http://access.tarrantcounty.com/content/dam/main/juvenile-services/Documents/2016_PREA_Annual_Report.pdf?linklocation=Annual Report&linkname=2016 PREA Annual Report

The agency has instituted a new contract with all residential service providers they use that contains all the PREA requirements as well as the data collection component. The 2016 Annual PREA Report includes data from residential providers for 2015 and the data collection process is now formalized. The 2016 report is posted on the agency website. All providers are required to submit this data in June of each year to the agency. The agency is requesting that all providers send a copy of their completed Survey of Sexual Victimization data form. The agency is now fully compliant with this standard.

AUDITOR CERTIFICATION

I certify that:

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

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

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

Lisa A. Capers, J.D. October 28, 2016

Auditor Signature Date